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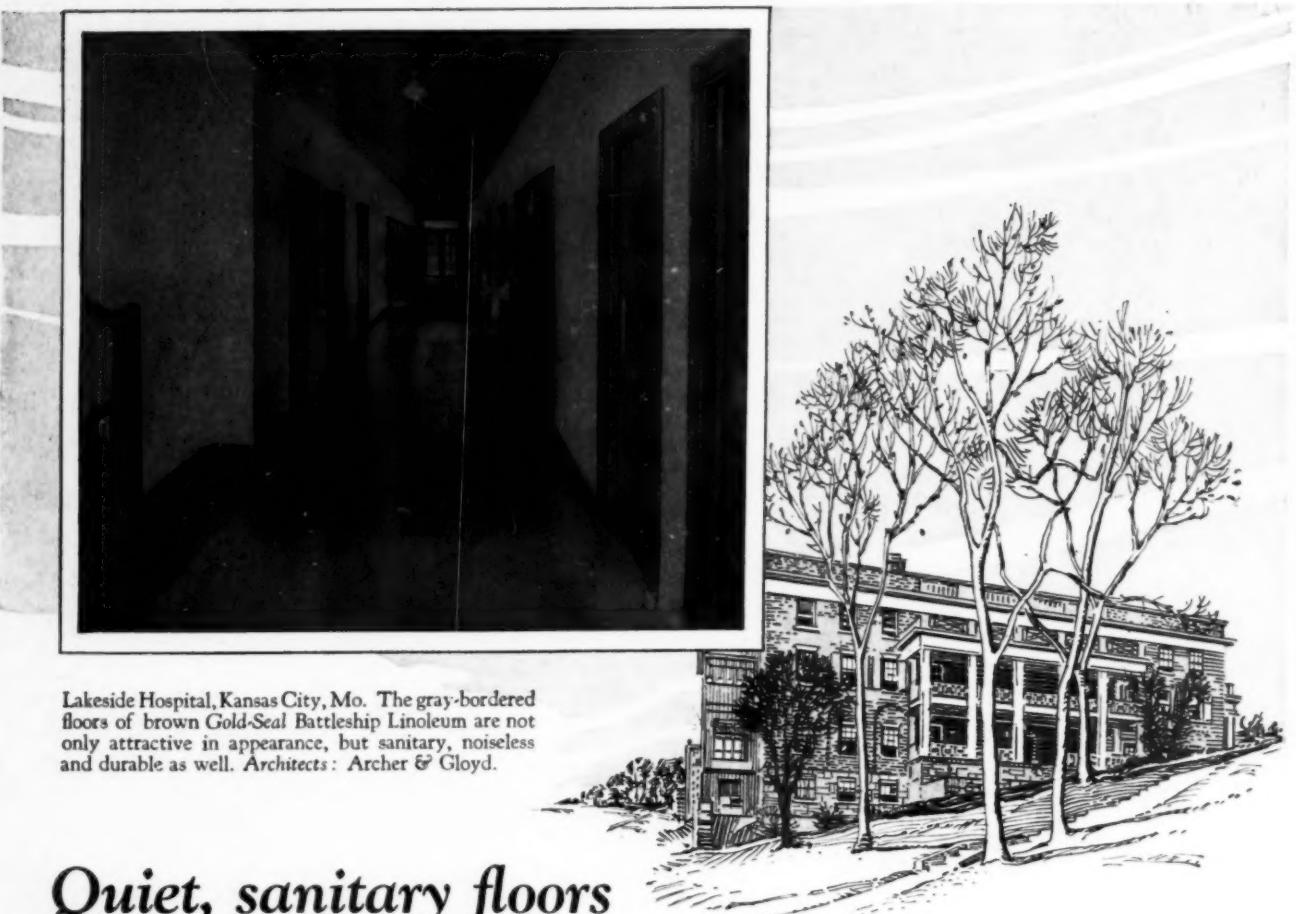


*The*  
**MODERN  
HOSPITAL**

Vol. XXV December 1925

No. 6

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Published monthly at 22-24 E. Ontario Street, Chicago, Ill., by The Modern Hospital Publishing Co., Inc.  
Entered as second-class matter October 1, 1918, at the Post Office at Chicago, Ill., under the act of March 3, 1879.  
Subscription—United States, \$3.00; Canada, \$3.50; Foreign, \$4.00.



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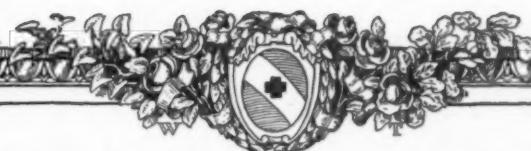
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# THE MODERN HOSPITAL

*A Monthly Journal Devoted to the Building, Equipment and Administration of Hospitals, Sanatoriums and Allied Institutions, and to Their Medical, Surgical and Nursing Services*

Vol. XXV

December 1925

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## SUPPORTED BY VOLUNTARY CONTRIBUTIONS

By S. S. Goldwater, M. D.

THE voluntary hospital in America boldly asserts that the world owes it a living. In England it is a sturdy and vociferous beggar, persistently crying its needs from the hoardings and the house tops and, like most professional mendicants, never quite satisfied with what it receives. No wonder that its appetite for money is insatiable, for it is host, year in and year out, to an army of penniless human derelicts, the unfortunate victims of hereditary taint, of social maladjustment, of ignorance, of poverty, of overcrowding, of the hazards of industry, of the fortunes or misfortunes of the public road, or of common everyday human frailty.

There is a familiar phrase which is used to describe the means by which most hospitals live. It is said that they are "supported by voluntary contributions." An uncompromising determinist would, of course, maintain that in a purely mechanistic universe, a gift to a hospital is no more an act of free will than any other seemingly voluntary act. And some of the philanthropists whose names appear on the subscription lists of hospitals, painfully recalling the powerful pressure

that compelled them to put their unsympathizing hands into their pockets, would be tempted to concede their inability to act as free agents in respect to hospital donations, though they would probably continue to maintain that these are spheres of conduct in which free will does obtain—that a man is not obliged, for example, to choose a particular woman as wife or to wear a necktie of any special design.

### The Motive Behind the Gift

"A HOSPITAL gift may come free as forest air or it may be attached by a stubborn string to some puzzling idiosyncrasy; it may come singing joyously of a happy birthday. . . .

"A gift may be large or small, sweet or sour, a threat or a benediction, a tribute to conscience or a political gesture, the honest expression of a desire to serve humanity, or a cunning method of punishing a disobedient child. Hospital gifts have been employed as expressions of love, gratitude, friendship, memory, good-fellowship, pride of family, and pride of race."

There is some doubt about the virtue of those who give in so poor a spirit, but there is none about the sterling merit of their more generous (and happily, more numerous) associates, who periodically replenish the hospital treasury.

A hospital gift may come free as forest air, or it may be attached by a stubborn string to some puzzling idiosyncrasy; it may come singing joyously of a happy birthday or a family reunion, or it

may be the sad messenger of a sudden and grievous loss.

A gift may be large or small, sweet or sour, a threat or a benediction, a tribute to conscience or a political gesture, the simple expression of a desire to serve humanity, or a curious method of punishing a disobedient child. Hospital gifts have been employed as expressions of love, gratitude, friendship, memory, good-fellowship, pride of family, and pride of race. Often a gift is intended as an humble tribute to God.

The most inspiring of all gifts is the tiny offering of the almost penniless patient from whom nothing is demanded by the hospital, but whose grateful heart craves utterance. There is the case of the tottering man who, having just received a dime from the social service worker to pay his carfare home, stole back into the hospital, sought an interview with the superintendent, and offered the dime for the benefit of some needier patient, stoutly maintaining that he was capable of walking a distance of several miles to his home. And that other case of the painter, with earnings scarcely sufficient to meet the most urgent needs of his family, who insisted upon renovating the soiled basement corridor of the hospital, where he worked evenings, Sundays and holidays, and in a sustained effort of nine months, finished an extensive piece of work gratis to the hospital.

#### **Gifts That Are Inappropriate**

A truly magnificent donation may follow close upon the heels of a gift so small as to contrast pathetically with the rich emotion which accompanies it. But a large gift as well as a small one may be inadequate, as, for example, a memorial building, given on condition that it be used for a costly service of a specified kind, for which the donor of the building fails to provide. Think of a splendid research laboratory standing unoccupied and unproductive for years! An extreme case that belongs in this category is that of one of the most beautiful small hospitals in the world, its rooms and wards furnished with every comfort and in the most exquisite taste, its operating rooms perfect, the technical equipment of its laboratories of the very best, and the whole bestowed unsolicited upon a small community where no competent surgeon resides, and where modern laboratory procedures are unknown to the few old-fashioned practitioners of the neighborhood. There it stands, a pathetic monument to the thoughtless generosity of its donor, while the people of the vicinity who need hospital care seek out more distant institutions possessing qualified hospital staffs.

An element of self-seeking may sometimes be

suspected in hospital donations. The member of the workmen's circle who pays his monthly sanatorium dues may be thinking chiefly of his own possible future needs, though nine times out of ten his contribution is actually employed to benefit a fellow worker. The industrialist, legally or morally responsible for the medical care of injured employees, who gives a small subsidy to the local hospital, and who accepts in return treatment costing two or three times the amount of his annual subscription, is a dubious benefactor. Payments made by insurance companies operating under workmen's compensation laws, when analyzed, may be found to confer a benefit upon the company rather than upon the hospital, for by sharp bargaining compensation insurance companies often succeed in obtaining hospital service at less than actual cost.

#### **Generosity and Self-love Combined**

Occasionally a peculiar mixture of generosity and self-love is encountered. This is seen in the proffer of a needed gift of considerable proportions, to which obnoxious conditions are attached. A woman of known public spirit once offered to erect a needed lecture hall for a large hospital interested in teaching, but laid down the condition that the building be placed on the only piece of vacant ground in the hospital's possession which was suitable for an indispensable ward building. The acceptance of such a gift would have done more harm than good.

There are three classes of contributors that especially gladden the hearts of hospital administrators. The first is the grateful patient who, upon settling his hospital bill, adds a small sum in token of his appreciation of the kindly service he has received. The second is the annual contributor whose gift is not a momentary emotional response to a clamorous public appeal, but is the offering of an understanding friend who may be relied upon to contribute his quota in fair weather and foul. The third is the deficit guarantor, who gallantly stands by with life-preserving dollars when the hospital ship threatens to sink in a sea of accumulated debt.

When the Supreme Court of the United States finally decided that an income tax was constitutional, and when Congress voted that charitable gifts might be deducted from taxable income, the hospitals of the country won many unaccustomed supporters. Lukewarm friends, these, many of whom do not fully appreciate what the hospitals are doing, but who nevertheless would rather add some of their surplus income to the resources of a hospital than to Uncle Sam's swollen treasury. Contributions so influenced or determined should,

perhaps, be credited in part to our representatives in Washington, who, without expense to themselves, have through the exercise of their legislative functions aided and abetted all eleemosynary and educational institutions.

It would not be quite fair to mention Congress in this connection, and at the same time to withhold credit from members of state legislatures and of city councils, who regularly appropriate, for the benefit of private and semi-public hospitals, moneys raised by taxation. Such appropriations are sometimes made unconditionally and injudiciously, without inquiry into the relative needs or merits of the beneficiaries. It is a question whether these appropriations should be regarded as gifts, or rather as payments due to private institutions which have assumed the purely public duty of caring for the needy sick.

In this country community chests, welfare federations, and united hospital funds have widened the basis of hospital support, placing upon the whole community a burden which was formerly borne by the charitable-minded few.

#### Wide Range of Donors

Hospital donors may be primarily the friends of medical or, very rarely, of nursing education. Their chief interest may be in the promotion of medical science, or they may wish to improve the facilities of radical friends or relatives for clinical and laboratory investigation. They may be high-spirited gamblers who love the excitement of play, but who are unwilling to accept for themselves money won from friends in sporting fashion, and who gallantly pass their winnings on to a deserving charity. They may be profiteers guilty of sharp practices in business, who seek to ease troubled consciences by succoring a worthy cause.

In the past, the great world-famed foundations have seldom come to the aid of hospitals except by way of financing improved facilities for teaching and research in hospitals attached to university medical schools; but there are indications of a growing interest in hospital work on the part of some of the newer foundations, whose officers seem kindly disposed toward poor communities, unable to build and equip the hospitals they need.

One of the best friends of every worthy hospital is a modest person who prefers to be known as "Anonymous." There is little that the hospital can do to express its appreciation of the gifts of this warm-hearted and hydra-headed benefactor, other than to enumerate his gifts in its annual report, and to add a hearty "thank you." An equally fervent expression of appreciation is due underpaid hospital helpers of every class, especially those performing menial service at less than

the prevailing wage. It was one of these who, from the scant savings resulting from thirty years of hard work, bequeathed twenty-five dollars to the hospital which had underpaid her during all that time, reserving the balance for her funeral expenses.

#### Lifetime Service of Physicians

The devoted hospital physician has not been sufficiently praised in song or story. When, after a lifetime of self-sacrificing service, he happens to depart this life a celebrated man, he is sometimes accorded the recognition of a black-bordered page in the hospital's annual report. In the meantime, hundreds of his kind continue, year in and year out, with scant hope of reward in this world or in the next, to devote themselves to the hospital's poorer patients, restoring children to parents, wives to husbands, and wage-earners to their families. Must we talk in terms of money? Compare, then, the value of the unpaid service which is given by the medical staff of a dispensary in which a hundred-thousand free consultations are annually held, with the money required to meet its incidental expenses. If the cash outlay of the dispensary be fifty cents for each consultation held (an average figure), its annual budget will amount to \$50,000; against this set one hundred thousand skilled consultations or treatments at the very low valuation of a dollar each, and it becomes evident that the value of this service is double that of the untabulated dispensary budget.

Because the pride of a giver now and then outruns his possessions, or because, in a period of fluctuating prices, no investment is absolutely secure, hospitals are sometimes advertised to the world as the fortunate receivers of magnificent residuary estates of which the actual residue is often impalpable. A dollar is a dollar, but precisely what hospital commodities a dollar will buy twenty years after a will is made, nobody can say.

A short time ago, the whole world was aroused by the story of the London hatter who for years devoted his spare time to microscopic work in a medical research laboratory, and who thus contributed in an important way to the elucidation of one of the causative factors of cancer. Such part-time volunteers are numerous in this country, though the results of their labors are not often so fruitful or spectacular; they may be found, both men and women, working in hospitals without compensation, as photographers, laboratory technicians, librarians, registrars, and seamstresses, accountants, statisticians, purchasing agents, advisers, and social service volunteers.

Money and service are the two great categories into which hospital donations fall. Those who

serve as hospital trustees are expected to give both. Of considerably less importance are gifts of innumerable articles, some of which the hospital finds useful, while others it accepts with becoming courtesy but secretly discards at the first opportunity. Into every hospital there pours a constant supply of articles, useful or troublesome, beautiful or ugly, such as flowers, fresh and decayed; fruits and table delicacies which lessen the monotony of hospital fare; musical instruments, appropriate and inappropriate to hospital use; surgical and medical appliances, new or outworn; a multitude of patent medicines which no self-respecting staff would think of prescribing; dilapidated invalid-chairs which the social service department uses if it can; toys from sickrooms which the prudent pediatrician immediately orders banished or burned; books, newspapers and magazines, high-brow and low-brow, to improve or deprave the taste of convalescents; misfit clothing, shoes down at the heels, and stockings full of holes; household furniture of all periods and of no period; aberrant sculpture obnoxious to the discerning eye of the trained anatomist; the dreary canvases of unknown masters; braying brasses; exotic bric-a-brac; embroideries extraordinary; and, finally, an inexhaustible stream of free criticism and advice which the wise hospital administrator, dimly conscious of his faults, receives without rancor and, let us hope, never forgets. Rarer than bequests of money, service, or bric-a-brac are legacies in which the testator, eager to aid in the promotion of science, bequeathes to the hospital in fee simple the earthly tenement of his soul, and thus achieves a signal triumph of mind over matter.

The living substance of part of the human body, as well as the total but exhausted remains of a testator, is sometimes used to fulfil the purposes of the hospital. Sections of bone are excised and transplanted, human skin is skilfully grafted to cover areas denuded by burns or injury, rich red fluid flows through a tiny canula connecting the artery of a full-blooded donor with the vein of a recipient whose blood has been impoverished by disease or sudden traumatic hemorrhage, and precious human milk is transported from a mother who has lost her child in one hospital to an infant prematurely born of a physically incompetent mother in another. These services are sometimes paid for, but often they are the unbought and unpurchasable gifts of human kindness.

Some enterprising hospitals make an effort to capture their supporters young; they begin with the organization of junior auxiliary societies in Sunday schools and kindergartens, where tiny toddlers are cajoled into sacrificing their penny

allowances for the benefit of some crippled hospital child. Any American youngster may look forward to becoming president of the United States, but the kindergarten child who yields up his weekly portion of sweets to aid a helpless hospital cripple, may hope to attain the more exalted position of president of a hospital board.

A hospital may be the lengthened but tenderly distorted shadow of a crusty millionaire, or it may derive its sustenance from a very large number of small contributors. There are hospital drives in which hordes of sheepish individuals are forced into the hospital fold by a professional campaign manager who is quite as alive, alert, and intelligent as a Scotch collie; raffles in which a once powerful eight-cylinder motor car of ancient make, "dolled up" for the occasion, attracts the hard-earned dollars of innumerable owners of "tin lizzies"—secret aspirants to the mastery of the road; bridge parties in which the game is always won by the hospital; and afternoon teas at which the hostess will drop a slice of lemon or a lump of sugar into your cup in exchange for an oblong piece of greenish paper shot through with silk threads, such as hospitals devour by the million.

#### The Future of Contributions

Will the present system or lack of system for the maintenance of hospitals endure? Who can say? Tithes were established by the Hebrews in ancient times to insure the support of their religious institutions, and were revived by Charlemagne in the ninth century for the benefit of the Christian church. Notwithstanding the separation of church and state, it is easy to perceive a certain consanguinity between the ancient tithe and the modern income tax; and with the principle of the income tax once accepted, there is no form of public service that the enriched state may not undertake. If a single definite pattern is ever adopted for the support of hospitals in this country, it is almost certain to be a state pattern. Under a purely public or state system, the hospitals may be able to spend as much money as they are spending today, but the joy of spontaneous giving will be gone, and with it the humor and the pathos which characterize so many of the contributions of the present time. One shudders to think of the day when hospitals, transformed into soulless standardized state institutions, will be compelled to haul down the red flag of human brotherhood, which, alas! is so often entwined with the piratical black flag of a beneficent hold-up system. May that day be far off; and may American hospitals continue, for generations to come, to be "supported by voluntary contributions."

## SUPERVISING AMUSEMENTS FOR CONVALESCENT CHILDREN

By Abraham Levinson, M. D., Attending Pediatrician,  
and Esther Hornor, Play Teacher, Sarah Morris  
Hospital of Michael Reese Hospital,

Chicago

**T**HE city child usually spends his period of convalescence, that is, from the time the acute symptoms subside until he is walking about and eating his regular diet, in the hospital. To make this period as short as possible and at the same time guard the child from relapse is a real problem in hospital management.

The best way to make days of convalescence pass quickly is to make them pass pleasurable to the child. A little patient whose mind is normally full of happy thoughts and plans forgets his physical inactivity and the strangeness of his environment. There is no symptom more indicative of complete recovery than an attitude of contentment, even though the patient may still have the long hill to health to climb.

The most important problems to be considered in a discussion of convalescence are:

- (1) Diet.
- (2) Exercise.
- a. When shall the patient sit up and read?



- b. When shall he have the wheel-chair?
- c. When shall he walk?
- (3) Rest.
- (4) Visitors.
- (5) Entertainment.

Years ago patients received very little food, both during the febrile and the convalescent period. Whatever food was given to the patients was usually in liquid form. Now, however, it is commonly believed that febrile and convalescing patients require practically as much food as well persons. It is true that the gastro-intestinal apparatus, like every other system in the body, is below par and cannot handle a full diet. It is therefore necessary to supply the patients food that is easily digested and still has high caloric value.

Carbohydrates in various forms have been found helpful. Fruit juices to which large quantities of sugar have been added supply energy without burdening the system and are especially recommended except in cases of gastro-intestinal disturbance when protein should be given in large quantities and sugar in small amounts.

It is highly desirable to feed a child systematically during convalescence. At this time a patient requires about thirty-five calories per pound of body weight. Tables of caloric value of food are easily obtainable. It is best to make use of tables that give food portions of 100 calorie value.

After the caloric requirement has been determined, it is possible to select the most palatable food articles and the child must be made to eat what is given him.

In cases where a special diet is important, such as in diabetes or nephritis, the diet naturally should



The spirit of cooperation is taught to the children in their games and play.



The children are tactfully supervised during their feedings.

be prescribed by the physician who is in charge.

Convalescing children must be tactfully supervised during their feedings. Conversations should not be permitted. It has sometimes been helpful to give all of the children their bread and butter and vegetables, then serve the meat or fish and milk, and lastly the dessert. In the morning, cereal and milk may be passed first in order that they be consumed before the eggs and fruit are passed.

It should be pointed out here that, in order to follow up convalescent patients properly, the patients should be weighed at least once a week, unless their physical condition does not permit weighing.

When should a child sit up in bed after an acute illness? The answer to this question is usually given by the child himself. You cannot force a child to sit up if he is too weak to do so any more than you can force a two months old baby to sit. When the patient's condition permits sitting up he will refuse to lie down. He will use every possible means to sit up or stand up.

It is the ambition of every child in the ward to get up in a wheel-chair. However, no child should be permitted to use a wheel-chair unless he has had a thorough physical examination, particularly in regard to the condition of the heart.

Walking should never be permitted until prescribed by the physician. The length of time allowed for walking or any other exercise should be gradually increased from day to day.

Exercise should be prescribed in the form of play. Even in orthopedic cases where exercise of certain muscles is needed, the formality of the ex-

ercise may be made pleasant enough to overcome some discomfort.

Every child in the hospital should have at least one hour of complete rest during the day. No matter how old the child may be or how many hours he is up and about, as long as he is convalescing, which his stay in the hospital would indicate, he needs an abundance of rest. A set rest hour is helpful. During that hour all the convalescing children are to be in bed and should either sleep or lie quiet. The room should be darkened and everyone who is not a patient, including the nurse, should stay out of the room.

The fewer the visitors and the shorter and less frequent the visiting hours, the better for the child.

Visitors are carriers of contagion to children unable to resist disease. Visiting periods never fail to leave the children restless, and at times weakened from crying over renewed separations. Visitors always leave their imprints on some temperature curve. When the child is critically ill the parents have a moral right to see the child as they have when the child is to undergo an operation. During convalescence, however, visiting should be restricted to one or two hours a week. Children should not be permitted to visit in a hospital for children. Adults should wear gowns and, preferably caps also, during their visits.

The therapeutic value of play in convalescence is fortunately attracting the proper attention. Most hospitals have some paid or volunteer worker who devotes certain hours in the week to the entertainment of the children in the wards. A hospital for children, supporting as many as a hundred beds, should have a kindergarten teacher spending three to four hours a day with the children from three to six years of age, and an occupational therapist working six to eight hours a day with the children of six to twelve years.

The usual kindergarten system in which free play with materials and cooperative play form so large a part answers very well the needs of the children from three to six years.

It is highly desirable that the kindergarten teacher or the occupational therapist be a nurse in order that she may appreciate the necessity of conforming with hospital routine and that she may cooperate intelligently with the nursing staff. She may also, because of her training, make observations of special symptoms. Unless

the doctor prescribes very definitely the work and play for each child, the teacher must use her own judgment in the matter. Just as each child is a problem in himself, requiring particular treatment and medication from the doctor, so he is a problem in himself to the occupational therapist.

Surgical cases remain in the hospital only a week or two. If they have passed their convalescence in an active, happy state of mind, they go back to their normal habits the gainers, not only by the benefits of an operation, but by a whole set of new impressions. It is to these children that the lessons in personal hygiene taught in the hospital are most valuable. Here is an opportunity for nurse, doctor, and teacher to impress the child with the value of hygienic health habits. The joy of the bath, the duty of clean hands before meals, the comfort of fresh clean night clothes are only a few of the lessons to be learned in the hospital.

The medical cases—children suffering with carditis, nephritis, or chorea—present a great problem to the hospital teacher. It is to these children whose convalescence is slow, that the play-room apart from the ward is a real boon.

#### City Children Accustomed to Group Play

City children are unaccustomed to the free use of raw materials. They are, on the other hand, accustomed to group play, though highly competitive group play, where he who gets the most by fair means or foul, wins. As soon as they go to the play room, they want to discard the bedside "busy work," the games, puzzles and books which have been their only play outlet for weeks.

The hospital teacher has in this desire of the children to play with the group the opportunity to teach them cooperative play with no other end in view than the pleasure make-believe affords.

Here, and not in the making of small articles for an exhibit, lies the real work of the hospital teacher. No child is too weak or too young to find a place in the grocery store play. The boy who walks may be the delivery boy, but the girl in the wheel-chair is just as important in her role as cashier. If the children elect to play restaurant, they will delight in the details of preparing menus, of serving food, and collecting money. They may appoint their editors and reporters and write the news of the hospital. They may cut pictures and paste them into books for the children still in bed. They may make decorations for the walls of the ward or for the nurses' parties. A Punch and Judy show for which the children dress the dolls and write the lines affords unique amusement. In all of these plays the oc-

cupational therapist must constantly keep in mind the fact that she is moulding plastic material. Probably never again in the lives of those children will come the experience of such closely supervised play. All of the reasons why the cooperative work and play method is superior to the old method of giving each child something to do to keep his fingers busy, lie in the character development of the child.

We have always stressed the state of health of the child leaving the hospital, but we have never felt the responsibility for the state of mind he has developed during his stay. It is in the illnesses of childhood that the self-centered, self-pitying, chronic invalids form their habits of mental idleness.

The group project does not always provide entertainment for all of the children, particularly for those who must stay in bed all of the time. They must be kept interested, too. If the therapist has comparatively few children to entertain, she may give those bed patients light craft problems just as long as they find entertainment in them. A sick child should never be made to finish something which no longer interests him. His new problem must be shorter and simpler. Indeed, the therapist has made a mistake if she has given the child something to do that he does not want to finish. If she has too many children to be able to spend a long time at one bedside, she may find puzzles, blocks, peg-board, dolls to cut out, pictures to color, balloons, wooden beads, and construction toys very helpful. These things, if properly cared for, may be used over and over again.

#### The Hospital as a Character Builder

Sometimes the whole character of the child seems to change for the better during his hospital sojourn. We have long known the therapeutic value of making the child believe that his work is useful and necessary, and that he is loved and loving. The occupations which keep him busy are a minor matter. It is the spirit in which he does his work that possesses therapeutic value.

Here are five groups into which some typical occupations have been divided for the use of the hospital teacher.

Group 1 is designed for the very ill child, the one just beginning convalescence, for instance, the child who is suffering from chorea or acute carditis and is in that hateful but necessary "absolute rest in bed" stage.

Group 2 is the light finger work for children convalescing after pneumonia, nephritis; children who are tired out by anything heavier than the least muscle play. The convalescing chorea case

will not be able, even at the time of discharge from the hospital, to coordinate well enough to use the fine finger muscles of the hands in the manner necessary in the work of group 2.

Group 3 is arm and finger work. The child will probably be sitting up in bed or chair for a short time each day when he makes use of this group.

Group 4 has in it almost anything that a child who is not able to walk may do. Stringing small glass beads and sewing cards are not listed, as beads strain the eyes and sewing cards teach sewing backwards.

#### Group 5 is for the walking child.

Of course special orders must be given for the child who has strained eyes or impaired vision and for the child who needs manipulation of special muscles. After all, these groups must be always fairly elastic. They must be made to fit the child—and not the child made to fit them.

A list of occupations for the groups is given below:

#### Group 1

- Listening to stories.
- Looking at picture books.
- Listening to music.
- Handling large light toys.

Reading for short periods after convalescence has progressed.

#### Group 2 (Finger work)

- Simple puzzles.
- Stringing large wooden beads.
- Making paper chains.
- Weaving with paper strips.
- Dressing paper dolls.
- Pegs and sticks.

#### Group 3

##### (Finger and arm work)

- Winding wool for dolls and balls.
- Weaving with bobbin.
- Colonial mats.
- Making and stringing paper beads.
- Coloring with crayons.
- Scrap book making.
- Parquetry.
- Mosaic blocks.
- Peg boards.
- Puzzles No. 2.
- Paper cutting and tearing.
- Basket making.

#### Group 4

- ##### (Arm work with pressure and some skill)
- Clay modeling.
  - Simple sewing.
  - Cutting dolls and furniture.
  - Construction sets.

Erection toys, furniture sets, wooden blocks, and peg boards.

Making paper flowers.

Puzzles No. 3.

Knitting and crocheting.

Painting with water colors.

#### Group 5

##### (Body work and skilled work)

Quoits and horse-shoe tossing.

Ball.

Embroidery and crocheting.

Black-board drawing.

Action games.

### AN OBITUARY OF A HOSPITAL

Recently a three-year-old hospital in central New York closed its doors, and by analyzing the last annual report the whys and wherefores of the "obituary" are apparent. There may have been circumstances that do not appear on the printed page, and if so final judgment should be withheld. However, here are the visible facts.

The town's population is about 2,800 and the hospital had a capacity of 100 beds.

The daily average of patients during the last fiscal year was twenty, the highest daily census was thirty-six and the lowest census was twelve.

The average cost per patient per day was \$13.33.

The actual deficit for the year was \$75,095.42, which was 76 per cent of the operating costs, and a portion of the remaining 24 per cent was represented by outstanding debts of \$5,861.61 due the hospital.

In the report appears the following paragraph:

"The custom of requesting one week's pay in advance continued throughout the year and has operated satisfactorily, although many people were admitted to the hospital without paying who were financially able to do so."

The donations dwindled each year and the cash on hand started with over \$6,000 the first year and ended with \$55.

The fallacy of "over-hospitalization" in supplying a bed for every twenty-eight people in the community is clearly demonstrated here. The cost per patient was excessive and the outstanding accounts were far too numerous, showing that the collection department did not function at all. The net result was a 76 per cent deficit and the final closing.

In regard to the hospital and its failure, one of the prominent members of the medical staff says:

"Throughout the constructing of the hospital no member of the board of directors, medical staff, or training school of our old hospital that the new one was to replace, was consulted in any way."

The most casual of preliminary surveys should have convinced the donor and the community that hospitalization on this elaborate scale was a waste and eventually would become a burden on the citizens of the town. The result has been that the community is now without any adequate facilities for its sick and the nearest hospital is twenty-two miles away.

By a proper survey, intelligently made, the community would have proper hospital facilities and the donor instead of being "soured on hospitals" would be a most enthusiastic hospital benefactor. He would have available to expend for further humanitarian causes half of the money that was wasted on the "white elephant."

## HOSPITALIZATION OF PNEUMONIA CASES: CHICAGO AMMONIA COMMISSION\*

### REPORT NO. 1

By C. C. Pierce, M.D., Senior Surgeon, U. S. Public Health Service Director, District No. 3,  
Chicago

**I**N DISCUSSING the question of hospitalization of pneumonia cases it should be borne in mind that pneumonia, either primary or secondary to a common cold, influenza or measles, is a communicable disease.

Dr. Carey J. Vaux, director of the Department of Public Health of Pittsburgh, Pa., presented a paper before the Allegheny County Medical Society meeting on November 18, 1924 entitled "Pneumonia from a Public Point of View."<sup>(1)</sup> He made the following quotation:

"Lobar pneumonia is a communicable disease which should be classified with the infectious fevers. If pneumonia were a new disease it would be regarded as 'contagious' and its spread would be guarded by isolation."<sup>(2)</sup>

"All students of epidemiology recognize that the pneumonias are disseminated by spitting, coughing and sneezing. If every physician, and other attendants of the sick, exercised well-known precautions, and did not carry infection from one patient to another or permit such infection to be carried, the mortality from pneumonia would be greatly reduced.... It is strange that with all the literature on the subject at our command, we should occasionally, even now, hear surprise expressed at the statement that pneumonia is contagious."<sup>(3)</sup>

In the paper from which the foregoing is quoted, Dr. Vaux clearly presented the idea that pneumonia is not a specific disease in the same way as

is measles or diphtheria. In other words, pneumonia may be caused by any one or by any combination of a number of pathogenic bacteria which find their way into the lung tissue.

The fact that pneumonia is not necessarily caused by one specific and definite organism does not, however, argue against its being a communicable disease. The department of health of Pittsburgh, in an official circular dated March 16, 1924, declared pneumonia to be a quarantinable disease, and specified the sanitary requirements to be observed when a case of pneumonia is cared for in the home. This action was endorsed by the Allegheny County Medical Society.

Endorsement of the Pittsburgh plan for pneumonia control by this county medical society is very gratifying in that it shows a changed attitude of physicians toward pneumonia.

monia during the past few years. An officer of the Army Medical Corps called attention to the fact that civilian doctors in the Army during the War apparently did not regard pneumonia as an infectious disease. He thought then that a great many physicians learned so to regard pneumonia, and that when they returned to private practice this information would be disseminated and would influence the attitude of doctors generally toward pneumonia.<sup>(4)</sup> Apparently such influence has occurred, at least in some localities.

All health officers know that the best way to control a contagious disease is to send the patients suffering from it to hospitals for isolation and treatment. Before recommending this procedure for pneumonia cases, data in regard to the effect of such action upon the patient, and upon the community, should be studied; especially should

\*The members of the commission include: Dr. Herman N. Bundesen, commissioner of health, chairman; Dr. C. C. Pierce, United States Public Health Service; Dr. Isaac D. Rawlings, director of public health of the state of Illinois; Dr. W. A. Evans, health editor of the Chicago Tribune; Dr. Edwin O. Jordan, of the University of Chicago; Dr. Carey J. Vaux, director of the department of public health, Pittsburgh; Dr. J. C. Geiger, assistant commissioner of health of Chicago, secretary.

A preliminary report of the commission was published in the Journal of the American Medical Association, March 21, 1925, Vol. 84, pp. 884-887.

### Where Shall Cases Be Treated?

THIS report of the Chicago Pneumonia Commission attempts to answer the question "Should pneumonia cases be sent to hospitals, or treated at home?"

Available data seems to indicate that pneumonia patients have a better chance to survive if left at home. This paper partly explains the higher hospital fatality rate. It points out that hospitals are not responsible for the higher mortality rate and indicates several advantages in having pneumonia cases hospitalized.

Studies of hospital cases may answer the important question as to lowered body resistance and virulence of the infecting organism. Thus would be explained why certain persons contract pneumonia and others do not.

consideration be given to the advisability of such a procedure on account of the disease being communicable. Whatever conclusions are formed should be based upon statistical study.

Not many data are available in medical literature of the past four years in regard to the character of the cases, the method of treatment, and the mortality rates of pneumonia cases treated in general hospitals. There is also but little information available in regard to the most important phase of this subject, namely, the communicability of pneumonia, as shown by the occurrences of secondary cases in families where one pneumonia patient is treated at home and other members of the family are exposed to the case or to the same conditions as the first patient, and develop pneumonia; or of secondary cases developing as a result of contact exposure by hospital attendants.

#### General Data On Hospitalization

Such general data as could be found on the character of the cases and the mortality rates among pneumonia patients in hospitals will be referred to and discussed in order to ascertain what conclusions may be drawn therefrom. Certain other data in regard to hospitalized pneumonia cases will be referred to but not discussed in this article as the data deal with special phases of the pneumonia question, such as the effect of alcohol (<sup>11</sup>); treatment in military hospitals (<sup>12</sup>) (<sup>13</sup>); and the use of protein therapy (<sup>14</sup>).

Concerning pneumonia cases occurring in Pittsburgh from April 1, 1924, to October 31, 1924, the data shown in Table 1 was obtained (<sup>5</sup>).

	Lobar pneumonia	Broncho-pneumonia	Total
Patients treated at home.....	789	374	1,163
Patients treated in hospitals (residents) .....	368	141	509
Patients treated in hospitals (non-residents) .....	98	45	143
Coroner cases .....	49	8	57
Total .....			1,872

The above table shows 652 cases of pneumonia (both lobar and broncho) treated in Pittsburgh hospitals during the period indicated. Data in regard to the mortality of these cases are shown in Table 2 (<sup>6</sup>).

Deaths in Institutions and Homes (Pittsburgh) from Lobar and Bronchopneumonia, Seven Months Period, April 1, 1924, to October 31, 1924.			
Lobar Pneumonia:		Institution	Home
Residents	Non-Residents	205	67
		272	341
Residents .....	51	138	189
Non-Residents .....	33	0	33
		84	138
		356	479
			835

The mortality rates based upon the number of cases reported and the deaths recorded show that the mortality rate in hospitals was 13 per cent

higher than the rate for those treated in the home.

Whether the cases were at home or in hospital, and the mortality rates, are shown in Table 3 (<sup>6</sup>):

	Per cent
Citizens ill with pneumonia treated in their homes.....	71
Citizens ill with pneumonia treated in hospitals.....	29
Case mortality for all cases of pneumonia ((all resident) treated in their homes.....	41
Case mortality for all cases of pneumonia (resident and non-resident) treated in institutions.....	54
Case mortality for all cases of pneumonia of non-residents, brought into the city and hospitalized.....	70

The higher mortality of non-residents over the combined mortality of residents and non-residents treated in hospitals is a measure of the damage done to pneumonia patients by being moved and exposed, combined with the probable greater severity of illness of cases thought sufficiently sick to be sent away from home to a hospital. The development of complications in connection with the disease and poor home conditions were also probable reasons why non-residents were sent to hospitals in the city instead of being treated at home.

In considering the pneumonia mortality rate in hospitals, the figures in the above table must be examined with the following facts in mind: (a) Less than a third of the cases of residents were hospitalized; undoubtedly the most severe cases were sent to hospitals and the others kept at home: (b) The high rate of deaths among non-residents seems to indicate that pneumonia cases do not at all well stand moving from any great distance.

Data in regard to whether Chicago pneumonia cases are treated at home or in hospitals, taken from statistics on file (<sup>7</sup>) covering the period from January 1 to September 30, 1924, show the following:

Acute respiratory disease cases treated in hospitals.....	2,052
Acute respiratory disease cases treated at home.....	3,901
Locality of patient not designated.....	648
Total cases investigated.....	6,601

Nearly all of the above cases were pneumonia; some cases of influenza were included. In addition to the 6601 cases recorded above there were 1,054 other cases of acute respiratory diseases reported during the same period that were not investigated, making a total of 7,655 cases of acute respiratory diseases reported. Among these the deaths that occurred, and the location of the patient, whether at home or in the hospitals, is shown in Table 4 (<sup>8</sup>).

Table 4. Case Mortality Rates in Hospitals and Homes, by Three-Month Periods.				
January, February and March, 1924.	Cases	Deaths	Case Mortality Rate	Per cent
In hospitals .....	1,099	390	34.5	32.5
At home .....	3,096	791	25.5	67.5
April, May and June, 1924.				
In hospitals .....	776	324	41.7	37.8
At home .....	1,876	533	28.4	62.2
July, August and September, 1924.				
In hospitals .....	177	130	73.4	39.3
At home .....	631	201	31.8	60.7

Table 4 shows clearly that there was some tendency to hospitalize a greater proportion of cases, as the percentage of cases sent to hospitals increased from 32.5 to 39.3 from January to September, 1924.

The general mortality of all cases, both those treated at home and those treated at hospitals, showed a marked rise during the period, but a much greater rise took place among those treated in hospitals.

The home death rate rose from 25.5 per cent during the first quarter to 31.8 per cent during the last; while the hospital death rate rose from 34.5 to the appalling figure of 73.4 per cent during the same period.

In reporting upon pneumonia cases treated in a Cleveland hospital during 1918 to 1920, it was stated (9) that this hospital not only admitted all the civilians they could take care of but that they also gave beds to the student armies of Western Reserve, Case and Baldwin-Wallace Universities. All of the severe cases of pneumonia from these three institutions were sent to this hospital, but the mild cases were treated at the university infirmaries.

This report stated: "Cases that should never have been moved from their beds were sent here to die. Two patients died on the way to the hospital and one died in the hospital elevator on his way to a ward." There were also twenty-four deaths during the first twenty-four hours after admission, and in less than forty-eight hours eighty-nine out of 315 pneumonia patients died. Evidently none of these eighty-nine patients should have been moved. Tabulated data in regard to these 315 cases of pneumonia are shown in Table 5.

Table 5. Pneumonia Cases Treated in a Cleveland Hospital, October, 1918, to October, 1919.	
Total cases in hospital.....	315
Males .....	195
Females .....	120
Treated by outside doctors.....	112
Mortality in this group.....	69%
Treated by hospital staff.....	203
Mortality in this group.....	53%

Eliminating the eighty-nine deaths which occurred within forty-eight hours after admission, the mortality was 37 per cent instead of 53 per cent when all cases treated by the hospital staff are considered.

Table 6. Pneumonia Cases Treated in a Cleveland Hospital, October, 1919, to October, 1920.	
Total cases in hospital.....	113
Mortality rate of these cases.....	26%
Mortality rate of 41 cases treated by outside doctors.....	31%
Mortality rate of 72 cases treated by hospital staff.....	22%

These data seem to emphasize three things: (a) That severe cases only were sent to this hospital during the period reported upon: (b) That hospital mortality data for pneumonia cases are built up by cases sent to hospitals to die; (c) That the patients that were treated by the hospital staff had

a much better chance for permanent recovery.

This latter phase may be explained by the more constant attendance for stimulation and similar measures available for patients being treated by the staff, and also by the fact that those dying within the first twenty-four to forty-eight hours after admission were undoubtedly charged up to the doctor that treated the patient before he entered the hospital.

An analysis of pneumonia cases treated at St. Michael's Hospital, Toronto, during the period from January 1, 1920, to September 30, 1922, supplies the data in Table 7 (10).

Table 7. Pneumonia Cases Treated in St. Michael's Hospital, Toronto, January 1, 1920, to September 30, 1922.	
Total number of cases of pneumonia admitted.....	248
Total number of deaths among these cases.....	89
Cases of lobar pneumonia.....	152
Cases of bronchopneumonia.....	96
Total mortality rate (all 248 cases).....	35.8%
Mortality rate—lobar pneumonia cases.....	30.9
Mortality rate—bronchopneumonia cases .....	43.7
Mortality of all patients under 50 years of age.....	32.2
Mortality of patients over 50 years of age (all forms).....	56.0

It was stated that the majority of these cases came from the poorer parts of the city. The age groups were not separated except as shown above, so that among those under fifty would be included the very young, among whom the mortality is always high.

Probably many of the bronchopneumonia cases, among which the mortality was 43.7 per cent were cases of this type among children. On the other hand, the very old, that would be included in the over 50 group, also have a very high pneumonia mortality rate.

The most important reason for recommending that all pneumonia patients be sent to hospitals or be properly isolated at home would be the accumulation of data showing how pneumonia spreads from person to person in a family, the first case or the same conditions that caused the first case causing the secondary ones among those in contact with the primary case. The only data the commission examined on this subject was some information collected by the Chicago health department during February and March, 1924.

The difficulty in finding data of this sort prompts the suggestion that it would be of great value to health officers if doctors and hospitals kept systematic records of all known secondary cases of pneumonia that develop in homes and hospitals, and these data were published from time to time in current medical journals. Such information and reports should be kept, the reporter having in mind the possibility of contact carriers developing from a case that was not properly isolated; when such carriers develop they should be included in the records.

The Chicago data considered by the commission were the replies to a series of questions asked in

an investigation of 98 acute respiratory disease cases in Chicago during a brief period, February and March, 1924.

The tables following summarize the important facts recorded in these questionnaires.

Table 8. Multiple Cases of Acute Respiratory Disease.	
Total Number of Cases Investigated.....	98
Diagnosis given:	
Pneumonia, not classified .....	26
Pneumonia, lobar .....	15
Pneumonia, broncho .....	15
Pneumonia, pleuro .....	1 57
Bronchitis and influenza.....	2
Influenza .....	39 41 98

Among the 39 cases diagnosed as influenza that were investigated eight of the patients whose sputum was examined and "typed" proved to be pneumonia; seven of these were Type IV and 1 was Type II. These eight cases in which the diagnosis was changed from influenza to pneumonia are added to the fifty-seven cases of pneumonia shown in the above table, making a total of sixty-five cases of pneumonia.

Taking out of the above table the sixty-five cases of pneumonia, and arranging them in accordance with their occurrence in families, it was found that only thirty-one separate families (or houses) were involved, the group distribution being as follows:

Table 9. Multiple Cases of Pneumonia Investigated.	
4 instances of 1 case only in the house.....	4
22 instances of 2 cases in the same house.....	44
3 instances of 3 cases in the same house.....	9
2 instances of 4 cases in the same house.....	8
	65

The replies to four of the questions asked of these sixty-five pneumonia patients or their families are shown in the following tables:

Table 10. Query: Any other cases of acute respiratory diseases in the house during the previous month?	
Question not answered on the report sheet.....	6
Question answered "Yes".....	28
Question answered "No".....	31
	65

Table 11. Query: Has patient been in contact during past ten days with a case of pneumonia? With person recently recovered from pneumonia? With cases of cold, coryza or bronchitis?	
Question not answered on the report sheet.....	11
Question answered "Yes".....	24
Question answered "No".....	30
	65

Table 12. Query: Has patient had pneumonia before?	
Question not answered on the report sheet.....	10
Question answered "Yes".....	9
Question answered "No".....	46
	65

Table 13. Query: What does the patient or family consider as the cause or origin of the disease?	
Question not answered on the report sheet.....	10
Question answered "Exposure to cold".....	17
Question answered "Unknown".....	9
Question answered "Exposure to person with cough".....	6
Question answered "Exposure to person with pneumonia".....	4
Question answered "Exposure to person with influenza".....	6
Question answered "Whooping cough".....	3
Question answered "Measles".....	2
Question answered "Change of temperature".....	2
Question answered "Exposure to draft".....	1
Question answered "Damp flat".....	2
Question answered "Poor general health".....	3
	65

From the data discussed above and from other information obtained from medical literature and

not included in the above, there does not seem to be ample justification at this time for recommending that all pneumonia cases be hospitalized, because the hospital mortality rate is higher than the death rate of cases treated at home.

The hospital mortality rate is higher than it would be if there were a more general hospitalizing of pneumonia cases. Undoubtedly patients of the following types in which the mortality would be higher than usual are sent to hospitals for the reasons mentioned:

(1) Poor people living in lodging houses are more frequently sent to hospitals with pneumonia than are well-to-do persons who have comfortable homes and some one to take care of them.

(2) Tramps and others, picked up on the streets and in parks, when found ill, are sent to hospitals. Many of these are pneumonia cases and such cases usually show a high mortality rate.

(3) Pneumonia cases among the very old and the very young, in both of which groups the mortality is high, are more likely to be sent to a hospital than are cases in the middle period of life. The reasons for this are that the old are sent to the hospital so as not to be a care in the home; the young are sent to the hospital by inexperienced parents, and young couples living in boarding houses where they have no facilities for the care of the sick. Those cases in the middle period of life can more frequently be cared for at home.

(4) Cases of pneumonia simulating typhoid fever, meningitis, and appendicitis are usually sent to hospitals on account of a mistaken diagnosis. There is no inconsiderable number of such cases, and the course of these types of pneumonia is usually severe.

(5) Cases where complications result, such as abscess of the lungs, empyema, endocarditis and middle ear disease are sent to the hospital for operation and for the detailed nursing care required. Many deaths from these complicated cases are included in pneumonia mortality figures from hospitals.

(6) The post-operative and traumatic pneumonias are more frequently treated in hospitals than in homes. (These two classes of pneumonia are not being included in the Chicago data being collected.)

In referring to post-operative and inhalation pneumonias there is apparent justification for recommending that elective operations, such as tonsillectomies and adenoidectomies, should not be done during the period of the year when pneumonia is most prevalent. Information has been obtained by the Chicago Pneumonia Commission on the basis of which a recommendation was made to postpone all except urgent operations un-

til a more favorable season. Also, there is being considered a recommendation that the surgeon and other attendants at the operation, and those that have in charge the after-care of the patient, should be previously examined to exclude exposing the patient operated upon to a carrier of pneumonia organisms.

Taking the above into consideration it seems that the more severe types of pneumonia are usually treated in hospitals, and the mild types at home, thus explaining to some degree at least the difference of hospital and home death rates.

There are, however, certain advantages, both to the patient and to the community, in having pneumonia cases treated in hospitals. They may be summarized as follows:

(1) The value of nursing care in the treatment of pneumonia has been generally recognized. This sort of service can best be given in hospitals.

(2) Hospitals are better equipped to give special forms of treatment which may be developed, such as the injection of foreign proteins (<sup>14</sup>), use of diathermy, treatment by quartz light (<sup>15</sup>), giving of serum, vaccine or other biologic remedies devised to raise the patient's resistance to disease.

(3) Studies of the type and virulence of the infecting organism in pneumonia cases are facilitated by hospitalization of cases.

(4) Studies of the changes that have occurred in the patient causing his resistance to be lowered sufficiently to result in his developing pneumonia can be carried out in hospitals equipped for such research.

(5) The study of these two factors, namely, the type and virulence of the infecting organism and the elements of natural body resistance, may clear up the present obscure status of knowledge as to just what causes certain exposed persons to contract pneumonia while others do not, and what it is that determines the period of onset in any one particular individual.

(6) Pneumonia apparently spreads from a patient or carrier to at least some of the persons exposed through contact. Disinfection of nasal and buccal discharges is, therefore, important, and this can best be done when the patient is being treated in a hospital.

(7) Hospitalization of pneumonia cases lessens the number of contacts and thus limits the number of probable carriers that may result from such exposure.

It is advisable that health departments give out information to explain the reasons for the hospital death rate in pneumonia cases being higher than the rate of those cases treated at home. Health departments should also point out to the

general public and to physicians the advantages of having pneumonia cases treated in hospitals, provided the patient can be moved without lessening the chances of recovery.

Hospitals should be requested to make detailed studies of all pneumonia cases they have under treatment, and should be encouraged to carry out new methods of treatment, such as, for instance, the use of quartz light in the treatment of the pneumonias of children.

These measures should become a part of an educational program devised by health departments to give better control over the spread of pneumonia.

### Recommendations

Based upon the foregoing findings the commission has, therefore, made the following recommendations in regard to the hospitalization and institutional care of patients suffering from acute respiratory diseases:

(1) The visiting of persons suffering from pneumonia who are under treatment in hospitals or other similar institutions should be prohibited except in cases of actual emergency.

(2) Cases of pneumonia should not be treated in a general ward of a hospital, except that, when no other adequate care of such cases is feasible they may be treated in cubicles in wards, with properly instructed attendant and special disinfecting facilities, including proper solutions, kept close at hand; and bedpan, dishes, thermometers, towels and hands are properly washed and disinfected, and the nose, throat and mouth discharges of the patient are destroyed.

(3) Where there are several cases of pneumonia in the same hospital ward, cases due to different types of pneumococci or streptococci should not be placed in adjoining beds.

(4) Cases of pneumonia under treatment in hospitals should not occupy beds within ten feet of or otherwise be in close contact with persons awaiting operation or recently operated upon; with persons hospitalized for heart disease; with persons having Bright's disease; rickets; various forms of contagious diseases which might be complicated by pneumonia; severe burns or injuries, or other conditions which lower the resistance to pneumonia.

(5) The disinfection of nose, throat and bronchial secretions and of objects soiled by such secretions should continue after the patient's temperature returns to normal and so long as such discharges are present. The skin of the mouth, nose, cheeks, and hands of the patients and attendants should be frequently washed and kept scrupulously clean.

(6) Persons convalescing after pneumonia should not be allowed to visit or be visited by other patients, nor to expose unduly those convalescing from other diseases.

(7) The period of isolation should continue during the course of the pneumonia, and until non-infectivity has been determined by bacteriologic means.

(8) Patients with acute coryza, sore throat or bronchitis should not be operated upon under general anesthesia except in cases of emergency; nor should persons so affected participate in operations.

After each operation and before the next operation the anesthetic face mask, etc., should be properly sterilized.

(9) Whenever pneumonia develops to an exceptional degree in any hospital or institution, all persons in contact with the patients should be cultured for pneumococci and nearly related organisms, and when such organisms are found they should be "typed."

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## GETTING THE RIGHT MENTAL ATTITUDE

The advanced science of our day has much to say about the influence of mind upon body. The hospital is a place where there is grave need for definite attention to some of those psychological principles, if those principles are really of any worth.

When no drugs are administered, and nothing else is done that the patient can identify as treatment, he needs an explanation of the why and wherefore. If salt is taken out of his diet, he needs to understand the reason, so that he will not borrow from his neighbor's tray as soon as the nurse's back is turned. If rest and a right attitude of mind is the only prescription needed, then the doctors, or some one with authority to speak for them, should endeavor to make him understand and believe in the therapeutic value of rest, and a right mental attitude.

If nature does not need to be aided by drugs, it always does need to be aided by the patient's intelligent use of what mind he has. It is neither right nor efficient to leave him without anything that he can interpret as a direct effort to make him well. Some understanding of what is being attempted is one of his primary needs. Some knowledge of what he himself can do to help is another. The dispelling of his crude fears is another. Unless light is let into his thinking, panic terrors and wrong beliefs are likely to become fixed in his subcon-

scious mind with dire results. Correct information, wise instruction, firm but gentle encouragement, tactful and inspiring persuasion to rise up and master his sickness and handicap—these things he needs.

If the head physicians and their staffs are too busy for these things, then a new employee—a go-between—would add definitely to the hospital's efficiency. Such a worker could go to each patient on the day of his entrance, have a quiet talk with him, and explain the hospital method and what is first to be expected; he could go to him after the examinations and tests and explain their purpose and result; he could help the sufferer to understand the hospital and its system, the doctors and their efforts for him; he could endeavor to dispel vague fears and blind rebellions, and to change mischievous errors of belief into correct understanding; he could try to induce the patient to cultivate that mental and spiritual harmony that is an aid to cure and is needed for healthy living.

The hospital is dealing with more than bodies. It is dealing with the minds and spirits. If the doctors ignore this fact, the patients do not. It is not well that anyone should be able to say after a hospital experience, as a young literary man said to me within a few minutes, "I never met with such inhumanity before in my life; in a place that stands for humanity, the contrast is great."

If hospitals are to live up to what they stand for they cannot be regarded chiefly as places for doing a perfunctory turn of official duty, nor as laboratories for studying different kinds of disease, nor as training schools for giving young men their first experience at treating it. Patients must be treated as individual needy and suffering men and women, and there must be, in dealing with them, some attention to the delicacies and greatnesses of human relationships. There needs to be, on the part of those doing hospital service, something more than the keeping of hours, the performance of duties and the exercise of trained skill. If the pitiful cry that is brought to the hospital day after day is to be properly met, there needs to be a gracious bestowal of things that cannot be paid for, and that no man wishes to be paid for—the spiritual things that make human intercourse successful and noble, a joy, an inspiration and a power for help.—*The Survey*.

## THE REAL EXCUSE FOR THE HOSPITAL

In a recent talk to his house and intern staff, Dr. L. H. Burlingham, superintendent, Barnes Hospital, St. Louis, Mo., emphasized the point that the only excuse for a hospital is the patient. "The attaining of proficiency by our visiting staff, the training of our house and intern staffs, the training of nurses, research, and preventive medicine are all exceedingly important functions of a hospital, but they are all distinctly secondary to our doing in every way the best that we can for our patients. While this ideal is sufficient unto itself and requires no argument in its favor, as a matter of fact, no hospital can succeed unless its patients are well pleased. Pleasing a patient not only means that he shall receive the best of clinical attention, in history taking, examination, diagnosis, and therapeutics, all of which are most important, but that he shall not be treated as a case, but as a human being. Your contact with the patients is closer than that of any group in the hospital except perhaps, the nurses, and acquiring the habit of impressing your patients with the fact of your personal interest in them will mean much to them, and more to you later when you enter private practice."

## WHAT THE LIBRARY DID FOR PATIENTS AT FRESNO

By Sarah E. McCadle, Librarian, Fresno County Free Library,  
Fresno, Calif.

**I**N REACHING out and extending the lines of service of the public library to every corner of the community, which should be the mission of the public library, we have come to a fascinating corner—the hospital. Here is a branch located in a fertile field for service where it is not necessary to sit back murmuring a silent prayer for patrons. They are always at hand clamoring for things to read.

The Fresno County Hospital branch differs noticeably from those of eastern hospitals and in many of the larger institutions of the country where this service has been developing for many years. Unlike this hospital the majority are equipped with funds for books, and the salaries of the librarians are paid by the hospitals themselves. But some of these other branches were established in much the same way as ours, through small beginnings.

When it was decided that library service was

needed at our hospital, the superintendent raised no serious objections, as he believed the idea to be a passing fancy. Without further preparations books were selected from the branch department, a book truck was secured and a library assistant began to dispense the books which were kept in locked cases. Thus we established the precedent of library service in a general hospital. The public library furnishes everything except the little walled off corner in the corridor fitted with shelves by hospital funds.

At present there are 1,450 books in this branch. The circulation varies with the number of patients so that it may be anywhere from 900 to 1,400 books a month.

The work is in charge of two assistants from the public library who devote two afternoons a week, so that each ward is visited twice a week with a well filled book truck. At first difficulty was experienced in getting the right size of truck.



Each ward is visited twice a week by two assistants from the public library.

We have now our third design, and although hard to steer, it is an improvement over the other two used. The truck is thirty-nine inches long and nineteen inches wide. It has three shelves, the distance between the top and middle shelf being fourteen, and ten inches between the bottom shelves. The ends extend five inches above the top shelf. A one and one-half inch ledge on the outside of the top and middle shelves keeps the books from sliding off. The bottom shelf is used for magazines only. The length of the truck permits the shelving of twenty-six books so that the top and middle shelves accommodate 104 books.

Our manner of charging books to patients and other routine matters, and the variety of requests received from patients are undoubtedly similar to those in other hospitals.

#### Library at Old People's Home

The Old People's Home has a branch library visited twice a week. One hour of the librarian's time is devoted to reading to the patients. The shopping service carried on by the librarian is almost as extensive as that of a professional shopper. The books for the blind are borrowed from the state library and three times a year a teacher for the blind comes to the home.

A small library is also maintained at the tuberculous hospital. Monthly visits are made to this library. All books are first discarded before they are taken here and this is also true of books sent to the contagious ward at the request of the matron in charge.

It is unnecessary to dwell on the appreciations of the patients for this service. That is, of course, one of the inspirational and comforting things about the work. We believe that we are the means of bringing books to people who, in many instances, would not ordinarily have time to read, people who literally have to break a leg or have to be sick in order to enjoy the privilege.

Let us now turn our attention to a consideration of what we feel would be an ideal situation both in our own library and in our own general hospital. First of all is the medical library, the need for which has long been felt. Owing to our geographical location, we find that San Francisco and Los Angeles seem far away when we have urgent need for a medical book. A patient would have time to die any number of times before we could supply the material that would enable a physician to save him.

We would have our medical library located in the main library in a spacious room equipped by funds supplied by the county medical association. You will observe that throughout our plan we make it clear from what source funds will be

derived. A trained librarian with thorough medical training would be in charge. She will classify the books with a workable medical classification and turn them over to the regular cataloguing department to be catalogued. The salary of the librarian will be paid by the county library.

The books will be purchased by the library from a fund accumulated by a tax on the membership of the county medical association after being chosen by the library and medical board and approved by the county librarian. A collection of medical books given to us by the county medical association will be added to the collection. We also have subscriptions to ten medical journals from the same source to serve as a nest egg for the periodicals, journals and monographs that are the necessary equipment of a good medical library. There will be public health material, too, to be purchased with library funds.

The library will interchange medical books with other medical libraries. It will give service to the doctors of the medical association, public health officials, teachers, nurses and laymen, although only doctors and public health workers may take the medical books from the library for any length of time. This is our ideal for a complete medical library as a branch of the county library.

As for the future hospital library branch, we plan to have it centrally located in the hospital of which it is to be a part. It will have three divisions consisting of a room for medical and nursing books and for patients and members of the hospital staff. These divisions will be separated by glass partitions. The funds for the general part of the library, that is, the patients' books, will be supplied by the county library and those for the medical and nurses' collections will come from the hospital fund.

#### Two Full Time Librarians Needed

Two full time librarians will be in charge so that one may be on duty in the evenings. Although they need not be medically trained, they must have sufficient knowledge of medical books to enable them to give intelligent and immediate service, although they will have the advice of the medical librarian in charge. They will take charge of all institutional libraries then established, and will select books for these libraries. The actual ordering and purchasing of books, both medical and nursing, will be carried on by the county library in order to benefit from its discount and the facilities of the order department. The periodicals will be supplied by the county library for the patients and hospital staff and the medical journals will, of course, come out of the

hospital book fund. An arrangement will be made with the local post office to give all suitable uncalled-for magazines to the hospital library. Lists of foreign books will be procured from the publishers of foreign papers. The medical books will be selected by the medical librarian and the director of the hospital. If funds will permit the main medical library will have books for the blind, otherwise they will be borrowed from the state library. An active loan service will be carried on by the medical library and the hospital branch. Possibly the service for the general collection of books at the hospital libraries will be carried on as a branch service, as it now is, or it may be a separate department of the county library. Of course the children will not be slighted, for there will be story hours for them and an ample supply of picture books.

Hospital libraries of this nature would be instituted in all general hospitals; private hospitals would be served, if these desired, and service in the tuberculous hospital and other public institutions would be increased to a weekly schedule, if warranted.

### What Constitutes a Good Hospital Library?

Dr. H. O. Collins, superintendent of the Fresno County General Hospital, volunteered to outline his conception of a good medical or scientific library. We found his outline so interesting and complete that we are taking the liberty of passing it on.

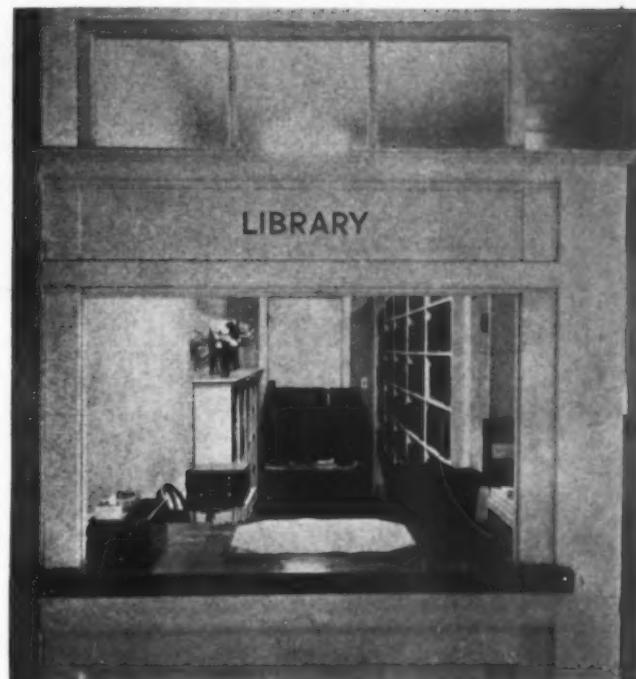
*Standard medical books:* Not a large number, but well selected, and old books discarded and replaced constantly with new. Should cover all branches of medicine, but include only two or three of the best on each branch of medicine. Should include several of the editions which are kept up to date by insertion of new material as it is supplied by the publishers.

*Journals:* At least one or two journals on general medicine, and the leading journal of each specialty. All journals should be carefully indexed by author and subject as soon as received. The index should be sufficiently complete to enable the reader to get in touch with the latest literature on any subject.

*Catalogue service:* Catalogues of other and larger medical libraries should be on hand, or some loan or exchange system established, in order that the reader may obtain books from other libraries, if possible. Such connection should be formed, if possible, with the libraries of one or two of the nearest medical libraries.

*Charts and diagrams:* A collection of latest charts, diagrams, manikins, etc., illustrating medical subjects to include especially anatomical charts, illustrations of pathological conditions, charts and diagrams of the appearance and life history of disease producing bacteria, maps and charts illustrating the geographical distribution of various diseases, charts on public health service, etc. These should all be carefully indexed for ready reference.

*Reference or research service:* A service to enable members of the hospital staff to obtain quickly a very brief resumé of the latest literature on any subject. When



The branch library showing the bookstacks and book truck.

a request is made the librarian would look up the subject in the latest textbooks, and journals and make short notes of the most important points with complete reference by which the subject may be followed further if the reader desires. The report should be typewritten and delivered to the client as promptly as possible, always remembering that a patient's life may be at stake. But copies of the report should be indexed and filed in the library for future reference.

*Monographs:* A collection of monographs, reprints of medical articles, printed copies of articles read before medical or other scientific societies, copies of the "transactions" of medical and hospital and public conventions, should be indexed for ready service.

*Nursing:* Textbooks and journals devoted to the nursing profession, nursing education, public health nursing, hospital social service, and visiting nursing.

*Hospital administration:* Textbooks and journals, reprints, monographs, and reports of interest in connection with hospital organization, planning and administration, building, equipment, etc. In this might also be included a library of catalogues of hospital supplies and equipment as published by the leading firms selling such articles.

*Patients' library:* Divided into books for chronic patients or "shut-ins," books for the acutely sick, books for children. Few patients in a hospital want heavy reading so that the ordinary books found in the average circulating library will be suitable for chronic patients. They should include a larger amount of fiction, but few ordinary reference books. They should be in various languages suitable to the locality, and include a fair number for the blind. The leading daily and weekly papers and magazines should be included. For the acutely sick, short story books, small enough to be easily held in the hand of a weak person. A large number of papers and magazines, especially illustrated papers, books of jokes and short anecdotes. Type should be clear and easily read. Depressive books, and those calling for much continued effort should be carefully avoided.

*For children:* The usual children's books, picture

books, stories and fairy tales. Scrap books are especially desirable for children. They can be cheaply made and burned up when dirty or when there is the least suspicion of infection. If a suitable place can be found the convalescent children will greatly enjoy helping to make these scrap books. In some hospitals it might be part of the librarian's duty to take children who are able to go out on the lawns and read to them.

*Housing the library:* The medical library should be centrally located, easy of access to the staff. The reference books at least should be available at all times, day and night. The room should be large enough to constitute a comfortable reading room. For the acute or bedfast patients, bedside service, if necessary. For the chronic and the convalescents there should be a large reading room where they can spend their time in reading. It should be a cheerful room with sun-porch, easy chairs, couches, attractive pictures and blooming flowers.

Considering the fact that we spoke to Dr. Collins late one afternoon and that the next morning he handed us this comprehensive description of a hospital library complete in every possible detail, we have come to the conclusion that we are not alone in having long harbored dreams of ideal hospital libraries.

#### Advocate Promotion of Library Service

From the standpoint of the need felt by this library for a well planned organization of hospital library service of the future, the greatest step forward was taken at the Hot Springs, Ark., meeting when the Hospital Round Table formulated resolutions to present to the American College of Surgeons, and to the American College of Physicians requesting that they "include in their respective reports on hospital standardization a recommendation to the effect that hospitals shall call on the public libraries of their communities to be responsible for library service in such hospitals." This would be the lever prying open the purse of the body controlling the finances of the hospital whether city or county. Also, it would come to them as the request of the director of the hospital bringing forward the need from the many angles of service—professional to the director and his staff, and therapeutic to the patients. It is most difficult, if not impossible, from a monetary standpoint, to demonstrate to a medical board or a board of supervisors or to a city council, such a need; but if the request comes not from the library wishing to give the service but from the hospital authorities who must count all costs and keep the institution on as small a working basis as is possible, greater emphasis will be made and consideration consequently shown. Demands from the people or the institution to be served, particularly if the latter is a public one, must always receive the close attention of governing bodies who depend on popular election for their terms of service.

#### TELLING THE PATIENT WHAT THE RATE COVERS

Often when the patient is presented with his bill he will immediately question its accuracy and decide without further analysis that the hospital is trying to make money off him. Although the amount is explained to his evident satisfaction, he goes away feeling that he has been made the victim of a vicious system when he was helpless. He "understood" that the charge was so much a day and that it included everything. The superintendent is at a loss to find upon what this misunderstanding is based and the patient also is vague as to its source.

As a result of this ungrounded idea the hospital suffers through the indignant report that the patient, upon his return to his home and neighbors, gives to all.

Careful explanation to the patient, upon admittance, is one way of partially overcoming this misunderstanding. It is obvious that the superintendent cannot interview each new arrival and often the task of explaining is delegated to an assistant who, by constant repetition, drones through the words without conveying their meaning to the mentally agitated entrant.

One large hospital has elaborated upon a system used by some hotels, in presenting to the patient a card similar to the card given to hotel guests. A written explanation of just what the charge is per day, of what the rate includes and of what the extra charges are, as well as of the extent of responsibility toward money and other valuables, gives the patient a clear understanding so that when his bill is rendered he knows what each charge is for and is less apt to be dissatisfied.

##### The Rate for This Room

Is \$..... Per Day

This rate includes, room, board, ordinary medicines, surgical supplies and attendance by the interne staff and the floor nurse.

The hospital rates do not include the physician's or surgeon's charges. In all cases the patient must arrange with the physician or surgeon for his fee, and all such fees must be paid direct to him.

The charges for special nurses are extra, and are payable direct to them, by the patient.

The hospital makes an extra charge to the patient for the special nurse's board.

A friend or relative of a patient will not be served with trays or permitted to occupy a cot in a patient's room except in extreme cases. An extra charge will be made for this service.

Extra charges will be made for laboratory examinations, use of operating rooms, use of delivery room, x-ray, special baths, unusual medicines and excess surgical dressings.

The hospital will not be responsible for money or valuables kept in the private rooms or wards. Such valuables must be turned over to the cashier or to the head nurse on the floor.

All bills are payable weekly in advance.

The history of hospitals, especially in the Occident, is down to the end of the twelfth century closely connected with that of the xenodochia. In the western countries separate institutions were established chiefly through the efforts of Innocent III, and the founding by him of the Hospital San Spirits in Rome in 1204, which served as model for numerous similar institutions in all Christian countries, mostly under the same name, may be considered as the beginning of the history of hospitals in the Occident.

## RESPONSIBILITY OF THE HOSPITAL IN THE PREVENTION OF DISEASE\*

By Howard Charles Carpenter, M.D., Children's Hospital,  
Philadelphia.

**I**S IT not time that hospitals should realize their responsibility to the community in which they are located for the prevention of disease and the promotion of health? It is a fact that the hospital is the only organization which has the equipment necessary for this purpose. For prevention work, everything which the hospital has in the way of equipment may be utilized.

The excuse usually offered for the failure of hospitals to undertake preventive work is that public health work should be conducted from municipal health centres. I am a firm believer in municipal health centres and hope to see them established to a much greater extent in all municipalities, but I question if there is a health centre in this country that has adequate equipment to do a hundred per cent job in the prevention of disease. On the other hand, there are few hospitals in this country that do not have adequate physical equipment to do it.

I am looking forward to time in the near future, when some progressive board of managers, with a wide-awake medical staff, will decide to turn over a well equipped hospital for the prevention of disease, using its entire resources to this end. Patients will not be admitted for curative purposes; the staff will devote its whole time and energy to the prevention of disease. Such a hospital would do more than any one other thing to stir up this country to the fact that disease can be prevented, and that with our present knowledge, practically all the diseases of childhood can be eliminated.

### Responsibility of General Hospital

The responsibilities of a hospital in the prevention of disease vary considerably, depending upon the type of hospital. Certainly, every general hospital, be it large or small, should have a department for the prevention of disease. Even special hospitals should have such a department; especially all maternity hospitals and children's hospitals, because the younger the patient, the more effective are the results to be obtained in preventive medicine.

In maternity hospitals, results are best secured through prenatal work. This is the most neglected field in medicine and the results that can be

obtained are not generally appreciated. The wonderful possibilities of prenatal care will undoubtedly be shown in the next twenty-five years. Maternal mortality, which has been so grossly overlooked in this country, can be greatly reduced. The tremendous number of preventable deaths from congenital causes, for whose reduction such feeble efforts have been made, must be accepted as a failure on the part of hospitals to meet their responsibility to supply up-to-date prenatal care.

### Problems the Hospital Must Solve

What are some of the problems which a hospital should assume as its responsibilities to the community in which it is located?

(1) The improvement of the sanitary conditions surrounding the hospital. It is a frequent experience to see the worst type of housing conditions existing in the neighborhood of a hospital and apparently not of any moment to the hospital authorities. Both from a selfish and an unselfish point of view, the hospital should take an active part in the correction of such conditions.

(2) The control of communicable diseases. It is possible in many ways for a hospital to teach its neighbors to respect and appreciate the efforts of the health department. The hospital itself should cooperate in every way with the health department in preventing the spread of communicable diseases, and should definitely see that physicians in the neighborhood cooperate and report their cases. Hospitals should make adequate provision for the proper treatment of communicable diseases. Every hospital should be so constructed that proper isolation is available for patients with infectious diseases, as in many homes at the present time it is simply impossible to isolate these cases.

(3) Based on the responsibility of a hospital in the prevention of disease, we might formulate as a hospital function the promotion of the health and well-being of the citizens living in its vicinity. It should see that the citizens receive the benefit of the scientific prevention of all diseases for which there is a specific immunizing agent. Through modern educational methods personal and general hygiene, sanitation and domestic science should be taught. In fact, the hospital should be a model community health centre, one to which

\*Read at twenty-seventh conference of American Hospital Association, Louisville, Ky., October 19-22, 1925.

the citizens may wish to come for advice and help on all matters pertaining to health.

(4) I believe the one thing which is holding back preventive medicine more than anything else is the failure of hospitals in general to avow it openly and make it, a principal activity. If hospitals would do this there is no question that the members of the community would apply the information to themselves.

(5) It is a responsibility for the hospital to be willing to conduct health examinations for adults at least once a year; for school children at least every six months; for pre-school children at least every three months; and for infants at least once a month. This seems to me to be the least that a hospital should do. Hospitals have long been too conservative when they should be the leaders in public health work in the community.

#### Public Health Lectures

(6) Every hospital, in addition to conducting health examinations should give courses of public lectures on health and disease prevention. These lectures would undoubtedly attract large neighborhood audiences of people who desire information on health matters.

(7) The hospital should assume the responsibility of issuing free health literature supplied by the municipality, the commonwealth and the different departments of the United States Government. This should be done in such a way as to make the material really appreciated by the people.

(8) There are many ways in which a hospital with a department for the prevention of disease may cooperate with the state department of health and act as its local representative in health matters.

(9) Another responsibility of the hospital is to promote health education by making available to the people a free medical reference library, exhibitions of charts and models teaching health, motion picture exhibitions, slide demonstrations and, most important, the employment of a health teacher for group instruction to conferences of parents and health clubs for children.

(10) Another responsibility of a hospital which is not so generally understood is the moral effect that it can exert on the citizens and their families. When a member of the family is sick is the most effective time to teach that family its responsibility to the community. No chance should be missed to educate all people coming to the hospital on the prevention of disease. The dispensary waiting room gives a splendid opportunity to teach preventive medicine.

(11) I should like to stress the responsibility

of the hospital to supervise the health of families who are under the care of charity associations working in the community. For instance, in the hospital in which I am interested, during the past year over seven hundred examinations were made for the Philadelphia Society for Organizing Charity. Careful study by the hospital of each member of the family of those receiving help from relief agencies would quickly lessen the burden of the community in the way of charitable relief. This service is best rendered in a hospital department for the prevention of disease. Most astonishing results will be discovered in the large percentage of ill-health, and when the defects are corrected, most of the families will again be put on an independent and self-respecting basis. This is a service second to none that a hospital can carry out, as good health to a family that has had to throw itself on the mercy of the community is the first step in family rehabilitation.

(12) The responsibility of a hospital as a teaching centre covers many groups. For instance, it should be a training school for nurses, nursery maids, volunteer workers, dietitians, social workers, public health nurses, medical students, graduate students, interns, practicing physicians, parents, children, prospective mothers and the public in general.

#### Preventive Medicine in Nursing

In regard to nurses' training, is there any branch more neglected in the nurses' curriculum than preventive medicine? I know of nothing that I consider as important for them as training in this subject. Their conception of the health of children, gained only from ward and dispensary practice, is inaccurate, but assign them to duty in a health clinic and have them make home visitations under supervision, and their entire point of view in dealing with the sick and their methods of nursing will be radically changed.

Well do I remember a nurse, who, after graduating from a hospital, married, and asked me to come and see her sick child. During my examination she broke out crying and I explained to her that her child had a very slight bronchitis; but she replied that she was not crying at all about her own child, but about the babies in the hospital ward where she had been on duty. She said she would give anything in the world if she could go back and nurse those babies over again the way she nursed her own child.

The demand for public health nurses all over this country is well known, yet how absolutely inadequate is the supply to meet the demand. Much of the criticism of public health nurses that we hear from time to time is due entirely to the

fact that it has been necessary to employ nurses who have not had proper training. This is a responsibility which every hospital should try to meet, because to-day the public health nurse is our greatest instrument in preventive medicine; her training and education should at least be started in every hospital. If, as generally conceded, the hospital's responsibility is adequately to train nurses for the care of the sick, it is just as much a responsibility of the hospital to train nurses for public health nursing.

It is recognized that it is the hospital's responsibility to complete the education of the intern. In no way is it more important than in his education in preventive medicine. When he comes to the hospital, he has had practically no instruction on this subject, and as a result is not the least bit interested. His feeling is that it is all more or less waste of time. He does not realize that it requires a great deal more skill to examine the well than it does the sick. Many of the sick who come to a hospital already know what is the matter with them; but no well person who comes knows the state of his health, and no intern will know it either unless he is equipped to make a careful, accurate physical examination.

#### Protection Against Poor Medical Service

(13) One of the responsibilities of a hospital in the prevention of disease is the protection of the public against poor medical service. This is a matter which is not often considered in this light. There are still so many incompetent physicians that the public requires protection. For instance, many physicians are inadequately informed on the prevention of the diseases of children and it is right and fair that parents should be accorded the opportunity of bringing their child to a hospital where he may receive scientific preventive treatment.

(14) Another responsibility which the hospital has is that of scientific research in the prevention of disease. The development of the present social service department into a department for the prevention of disease under medical direction, opens a wonderful opportunity for its staff of physicians, social workers and nurses to increase our knowledge of the prevention of disease by medicosociological research.

If in this country we are to avoid the calamity of state medicine for the sick poor, the hospitals should realize their responsibility to do all that is possible to encourage preventive medicine.

(15) In order to "put over" a department for the prevention of disease it is necessary that the hospital board of managers be impressed with the necessity for it; and they in turn should impress

the administrative officers and the medical staff so that they may also be in favor of it.

Hospital managers should think twice before enlarging the number of beds in a hospital, particularly for infants and children, and instead should spend the money on a department for the prevention of disease.

Why is it that hospitals so frequently fail in their realization that they have a definite responsibility to keep well the people in their community? It is, I believe, largely because the meetings of the boards of managers are not well planned. Seldom does anyone ask at the board meetings: "What can the hospital do to meet its responsibilities in the community? Are we living up to our responsibilities in the expenditure of the moneys we have received from our appeals?"

The great mass of people do not understand what a hospital really stands for or what its function really is. Most of them believe that it is a place to go for operations. The fault lies with the hospital managers. They have failed to appreciate the need of educating the public as to how the hospital can serve them. From a purely selfish financial basis, the establishment by the hospital of a department for the prevention of disease would put the hospital in more favorable position to receive contributions for its support from the people of the community. I believe that hospitals should be granted appropriations based upon the amount of preventive work which they do, and that the state should fully remunerate each hospital for all the preventive work which it undertakes, as this is a legitimate expenditure of the commonwealth.

#### Health Activities Unified

One of the great advantages of having a special department for the prevention of disease is that it correlates, brings together and unifies all the various health activities in which the hospital is engaged. With the establishment of this department, the work will develop much more rapidly than would otherwise be possible. From the superintendent's standpoint it is an asset to have a department for the prevention of disease, to which he or she may turn over for investigation and action communications that have a public health aspect.

The social conscience of the hospital, which has been long latent, should take on an active phase and exert its powerful influence in its community, to investigate, study and prevent disease. It is time for hospitals to be cured of that chronic affliction called institutionalism, and branch out into leadership in the public health activities of the community.

## WHERE SHOULD MENTAL CASES BE TREATED?

By J. Allen Jackson, M.D., Superintendent, Danville State Hospital,  
Danville, Pa.

**I**N the past society has fixed the responsibility for the care and treatment of the mental patient on mental hospitals and the mental hospitals are endeavoring to fulfill their obligation to their respective communities. However, within recent years, society has changed its viewpoint toward the mental patient, what constitutes a mental patient, and at what point of his disease he should be hospitalized according to law, what treatment he should receive, how, when and where. Medical science also recognizes that mental disease possesses a wide range of symptoms from a nervous state to marked mental and physical deterioration and grave misconduct. At various points in this range the treatments indicated vary as widely as the points in the range themselves.

For practical consideration we must group these cases into workable classification from the standpoint of disposition as to treatment and agencies of treatment. Cases in the field fall logically into (1) defectives, idiots, imbeciles, morons; (2) epileptics; (3) dementes; (4) psychosis with somatic diseases; (5) the functional types, neuroses and psychoneuroses; (6) acute psychoses.

### Agencies Available for Treatment

The agencies available for this classified group are the home, preventoriums, the psychiatric hospital, the general hospital, and the mental clinic of either a general or mental hospital, and the mental hospital. In the assimilation of these cases, the various functions of these agencies may cross and recross and an individual patient may pass over the threshold of each agency.

Our greater duty rests, therefore, with a full knowledge of the case and the initial assignment. In the absence of noise, violence, destructive tendencies, homicidal and suicidal tendencies, and sex disorders, the following line of assignment is preferred: Home treatment, general hospital treatment, field clinic supervision, psychopathic services, then the mental hospital. Ordinarily, the delay in sending the patient direct to the mental hospital will in no way affect restoration, provided intelligent treatment has been carried on in the interim.

The general hospital offers untold possibilities for the mental patient. The attitude that may be to the contrary, a viewpoint based on tradition and, perhaps, experience, can be appreciated. Possibly it is due to a lack of facilities, a fear of

the reaction of a mental case on the other hospital groups, the fear of suicide, of homicide, noise, or destructiveness. Then, too, there is that old fear of having to keep an undesirable patient for a long period.

These are minimized, however, when it is recalled that hospitals are equipped with small rooms or dormitories, that may be temporarily barred or screened. Physicians and interns are now more familiar with mental diseases than in any period in medicine. Nurses are required to be instructed in mental and nervous diseases.

### Types to be Considered

If services are to be rendered to the mental patient practical consideration must necessarily revolve around the type elected to treat. In this election, there should be strong discrimination against admitting mental defectives, bed-ridden terminal dementes, paranoid, general paresis and cases with suicidal or homicidal tendencies. Some of these, although not suitable for hospital treatment particularly defective and mild demented types, may be efficiently supervised by the outpatient department.

The greatest advances in mental medicine have been brought about by the establishment of mental clinics, either as a part of the community service of a mental hospital, a general hospital or as an independent service of a social or health agency. In our clinics, eight in number, located at most accessible points to twelve counties, covering an area of 9,170 square miles with a population of 873,098 people, within the last three years we have rendered service to 800 cases, new and furloughed cases from the hospital. Sixty-five per cent of the adults examined were able to continue under adjustment in the field, and hospitalization was thus avoided. Undoubtedly there are clinics associated with general hospitals in large municipalities that can give as encouraging reports.

The object to be attained in the treatment of all mental cases is to promote recovery or to arrest the disease, in order that the patient may adapt himself to an independent plane of living or a place of community supervision or an institutional level of living. If the general hospital puts forth its effort to this end with each individual patient for a period of not less than two months or more than three months it has undoubtedly fulfilled its obligation to the mental patient.



Although this residence has been adapted for a small hospital without destroying its home-like atmosphere few residences can thus be converted.

## HOW A RESIDENCE WAS TRANSFORMED

By GRACE FOERTH HUNGER,  
Chicago

**A**N unobtrusive sign on the lawn is the only thing to destroy the illusion that the Maple Street Hospital, Battle Creek, Mich., is other than a private residence of unusual beauty of construction and environment. And that is exactly what the Maple street Hospital is—an intelligently planned home that was converted into a hospital five years ago. One comes upon it quite by surprise on the old tree lined residential Maple Street.

The vine covered two and a half story building is surrounded by a spacious well cared for lawn with several stately old shade trees, colorful shrubbery and seasonal flowers all of which make the porches and yard a haven for convalescents many months of the year.

The building itself is of dull gray stucco with a red shingle roof.

One comes upon it quite by surprise on a walk along the old tree-lined residential street of the town. It is called the Maple Street Hospital, and Battle Creek, Michigan,—that city of international reputation as a medical center—welcomed

its organization five years ago. It has the unusual distinction of being a hero in its own home town.

If the beauty of the exterior eludes the prospective patient, a feeling of security, warmth, and of friendliness is sure to encompass him upon reaching the entrance hall. Here, as elsewhere in the hospital, the interior decorations of the original residence have been preserved, so that one has the feeling of visiting in the home of a friend. The intimidating odor of anesthesia is noticeably absent, as the operating room is provided with an effective ventilating system.

### Home Atmosphere Preserved

There is nothing of the hospital atmosphere in the rich tones of brown and dull blue and burnished gold of the reception hall. The sturdy beamed ceiling and the woodwork are of genuine quartered oak. Large French doors of leaded glass, on both sides of the hall, lead into what were formerly the dining and living rooms, but are now two of the larger rooms for patients. Facing the spacious front porch, on both sides

of the entrance, are two more attractive rooms, one the erstwhile library, and the other the study. There is a fine Wilton rug on the hardwood floor of the entrance hall, and the over-stuffed brown leather rockers, with their high, comfortable backs, are conducive to a quietness of mind and body that hospitals rarely give.

Through the small arched doorway, shown in the picture of the hall is the rear entrance. The empty space under the stairway has been converted into a toilet room.

The culinary department and nurses' dining room are in a wing to the left of the stairway, and from what was formerly the morning room, to the right of the stairway, an elevator of the pushbutton type, has been installed. In this room convalescent patients may take their morning sunbaths. Adjoining the sunroom there is an ample bathroom with complete equipment.

A winding stairway, with treads and banisters finished in brown mahogany and the baseboards and posts in heavy cream enamel, leads to the second floor. The group of three large, graduated windows at the first landing is both a decorative and practical feature, since it provides the entrance and upper hallways with sunshine most of the morning and plenty of natural light the rest of the day. The walls are of plaster, painted a gray to provide a harmonious background.



The stairway at the end of the entrance hall. The archway to the right leads to the back door.



One of the rooms on the second floor, showing a bit of the Colonial influence. It is in soft tones of gray and cream, and the simple fireplace is of cream tile facing.

What comfort exudes from that huge, sun-drenched living room, with its two enormous windows flanking a beautiful fireplace of hand-carved quartered oak, with dull green tile facing. What cheer and confidence in returning strength must come to the patient as he enjoys the out-of-doors and flowers on the private porch adjoining the waiting room through the large French doors. The original wall paper was removed as inappropriate for the present purpose, and the walls are now finished in pale cream plaster. The wood-work, of course, harmonizes with the fireplace, and the hardwood floor here, as in all the rooms, is kept in splendid condition. The wall bracket lights are softened by amber cut glass beaded shades, and they as well as the adjustable bed light—a feature in all the rooms—afford an efficient and decorative lighting arrangement. Comfortable brown wicker furniture, a dull oak dresser with glass top, and taupe chenille rugs complete the furnishings. The ringing of bells, so irritating to the sick, has been obviated by the installation of a silent electric light call system. Each bed has its own pushbutton, and the blue electric signal, similar to the system used in large hospitals.

The room that was formerly the library still retains the beautiful leaded glass bookshelves of the original residence. Here a soft gray is used on the walls, and the paneled wainscoting and woodwork is of fumed oak. The well proportioned pressed brick fireplace boasts of real hand-wrought andirons.

The old dining room, left as it was originally except that its two windows were supplanted by a four-window bay, is finished in mahogany and has a paneled wainscoting surmounted by a painted burlap frieze in sombre greens, browns and reds.

Ivory enamel woodwork, with mahogany doors,



This six bed ward on the top floor was formerly the ball room.

has been adopted in all the second floor rooms. One room, in particular, has an especial appeal for patients. Its walls and drop ceiling are painted in a French gray, and the woodwork is ivory enamel. Two unusually large windows, with gray shades, flank a pleasing fireplace faced in cream tile. The mahogany dresser, the Windsor chairs, and all the furnishings relieve the room of the hospital atmosphere and make it essentially homelike.

The operating room and record room are on this floor. The sterilizing room, the operating room supply department and the operating room itself are in an "L" shaped suite quite detached from patients on that floor.

The third floor, where many a ball was held in the old days, has been converted into a ward for six patients. As is seen in the illustration, ten casement windows extend across the front of the ward. The wicker chairs and all the furnishings are of the same high standard found throughout the rest of the building.

#### X-ray Department in Basement

Part of the gray painted basement is utilized for an x-ray and clinical laboratory and the remainder of it is used for storage purposes, and the hot water heating plant.

The Maple Street Hospital is an example of what can be accomplished with suitable old residences without sacrificing anything in the way of sanitation or efficiency.

With a minimum of alterations it was easily adapted to use as an up-to-date hospital, with ten private rooms and a six-bed ward. It has recaptured and held that atmosphere of charm and intimacy which was a very real part of the old

home. It is this quality together with the efficient service that keeps the hospital filled and attracts a long waiting list.

#### PRESENTING THE HOSPITAL'S MEDICAL ACHIEVEMENTS

In answer to the question, "In what manner can the hospital's medical achievements be most effectively presented to its supporters and to the public?" Dr. Herman Smith, superintendent, Michael Reese Hospital, Chicago, states:

"There are two types of medical achievement. The first, and by far the most important, is constant and continuous good medical care to all patients. The publication of this work need not be artificially fostered, as it will spread very quickly through any community. I firmly believe that it will spread almost as quickly as poor medical work.

"The second type of medical achievement is the holding of teaching clinics and the publication of articles by members of the staff. The news concerning teaching clinics is very quickly spread through the community by the various patients concerned. To my mind, the best way of spreading information concerning the types of clinics held and the articles published is by having the medical staff annually or semi-annually report to the board of directors upon these matters and forward to the board the titles of the paper in question. The board, if it has any interest at all in the hospital, will quite effectively spread the news through the community, particularly about outstanding medical contributions."

#### HIGH PERCENTAGE OF AUTOPSIES AT MOUNT SINAI

As an evidence of the increase in the percentage of autopsies that are being made by many of the larger hospitals of the country is the record of Mount Sinai Hospital, New York, which reports an average of 60 per cent of all ward cases, for the past five years, according to Dr. E. M. Bluestone, assistant director. This report is all the more significant when it is considered that a large majority of the ward cases of that hospital are Jewish.

## SOLVING THE WASTE PROBLEM

By Helen A. Parks, R.N., Assistant to Superintendent of Nurses, Rhode Island Hospital, Providence, R. I.

**E**FFECTIVE handling of the waste of a large hospital demands the intelligent and conscientious cooperation of all departments. Checking and reporting on waste material is essential; first, to save that which is not legitimately waste, and, second, to reveal faulty or extravagant use of supplies.

At the Rhode Island Hospital seven types of waste are collected in separate utensils in the various departments:

(1) Garbage or waste from food supplies (except bread waste).

(2) Waste bread, such as is returned on patients' trays.

(3) General refuse, such as sweepings.

(4) Used dressing materials (except gauze).

(5) Used gauze.

(6) Old newspapers.

(7) Broken and worn articles and utensils for exchange.

With the exception of the last item, the collections are made daily, a low platform hand truck being used to convey the containers, on which the ward name is painted in large letters. The garbage and refuse containers are large, covered, metal cans which are collected in the morning and replaced by clean receptacles.

At a convenient distance from the hospital buildings and attached to the boiler house are the garbage house and incinerator, with a concrete area occupying the ground immediately in front. The former is merely a small brick room with a drained concrete floor, and a door which is covered with wire screen in the upper half to allow free circulation of air. Along one side are ranged the barrels which receive the garbage from the ward receptacles.

Upon being brought from the hospital, the garbage is slowly emptied in the presence of a representative of the dietetics department who makes note of its condition, paying particular

attention to the predominance of any one article of food, over-thick peelings, or excess of water. Inquiry as to the cause of excess of any particular food stuff in the waste, may lead to the detection of faulty cooking, seasoning, or serving, or of a lack of taste for the article on the part of the individuals served.

The barrels are removed daily and replaced with clean ones by the man who buys the garbage for hogs; the floor is flushed with a hose and the ward utensils are thoroughly cleaned, and aired until distributed at the next morning's collection.

Bread waste from the wards is collected separately and returned to the diet kitchen where it is weighed before being consigned to the garbage. A record is kept of the daily return from each individual ward, and a copy of the record is given each ward supervisor weekly, in order to help her to correct faulty serving. In this connection it is interesting to note that there is always more bread waste from women's than men's wards, although the amount ordered for the latter may be proportionately larger.

The incinerator in which refuse is burned is built of brick and opens into the chimney of the boiler house. It is fitted with a grate, and immediately in front of it is a bricked area about six feet square, with a concrete floor on which the refuse is spread for examination. The containers are emptied slowly under supervision of a responsible person, who notes and causes to be removed gauze or other articles which do not properly belong in the refuse. The porter who handles the refuse wears heavy rubber gloves and picks out the paper, wood, and non-combustible articles as he shovels it into the incinerator. The paper is removed to the press at the baling machine, wood is added to the kindling pile, and

### Strike at the Source

**P**ROPER handling of institutional wastes depends upon the careful organization of the institution involving the full cooperation of the workers; the careful study of each waste source; the recording of facts and statistics concerning the wastes; the making of definite plans for elimination of wastes and applying the plans in the different departments by giving definite instructions to workers and supervisors. Placing responsibility upon different individual workers and enlisting their interest gives them an incentive to minimize the wastes in their respective departments. The efficiency of any system of waste disposal depends greatly upon proper consignment of the waste at its source, and involves constant vigilance on the part of all supervisors and department heads, especially where there are frequent changes in personnel.

non-combustible articles are put into a barrel which is eventually emptied on the city dump.

The incinerator is thoroughly cleaned weekly, ashes being sifted, and mixed with loam for use in the garden, and the residue sent to the city dump. A record is kept of all articles found which are out of place in the refuse, together with the name of the ward or department. This is reported in writing to the hospital superintendent and training school office. The record is posted daily on the school bulletin board. Thus a friendly competition between wards in proper waste disposal is established.

Used dressing materials are placed in small bags on the ward and are collected with the refuse each morning. To avoid handling they are put into the incinerator after the refuse is inspected, as are the remains of plaster casts.

The dressing pails which receive the soiled gauze on the wards are lined with white cotton bags, in which the gauze is sent to the laundry. There it is washed, sterilized, and partially dried. While still damp it is stretched into shape, a duty which is assumed by one of the hospital "pensioners" with the help of convalescent patients. Gauze from wounds infected with spore-forming organisms, such as anthrax, is burned with other dressings.

Newspapers from all departments, together with the waste paper from the refuse, are put directly into the press of the baling machine. When enough accumulates the paper is baled by the head porter. Last year about \$225 was received for baled paper.

#### Condemned Articles Inspected Each Month

Articles consigned to the condemned goods box of each department are collected and inspected monthly. Those which can be used without loss of efficiency are returned, while the rest is sorted with the refuse, after being listed for replacement on requisition.

Besides the general waste, special departments have wastes peculiar to themselves. In the linen and sewing room clippings, threads and discarded linen are collected and sold as rags for one and a half cents or two cents a pound. Empty ether cans from the operating room are collected and placed with material for the dump. Because of the risk involved if a partially empty ether can reaches the incinerator, the finding of one in the general refuse is the occasion for an interview with the superintendent. From the steward's department comes the wood from the shipping crates and other sources. Large pieces are carefully separated and placed in the lumber room while small pieces, such as boxes, are broken and

piled for kindling. All excelsior is burned within twenty-four hours because of fire hazard. The leaves which are raked from the lawns in the fall are buried in a corner of the garden to rot for plant loam for the next year.

The efficiency of this system of waste disposal depends greatly upon proper consignment of the waste at its source, and involves constant vigilance on the part of all supervisors and department heads especially where there are frequent changes in personnel. In this problem as in all others an intelligent understanding on the part of the workers and a proper *esprit de corps* are essential to the success of the plan.

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#### THE TECHNIQUE OF AUTOPSY PERMITS

The following advice regarding autopsy procedure was recently offered to the house and intern staff by the superintendent of one of the large hospitals of the country.

"When you talk with the nearest relatives of a deceased patient, be sure that they understand what they are doing when they sign the permission for autopsy. The administration will always try to give you any assistance in obtaining this permission. In getting permission for an autopsy always obtain the consent of the nearest relative, bearing in mind that a wife or husband, even if separated from the patient, takes precedence over all other relatives.

"Autopsy permits should always have: (a) Time of delivery; (b) coroners' cases; (c) complete or partial autopsy.

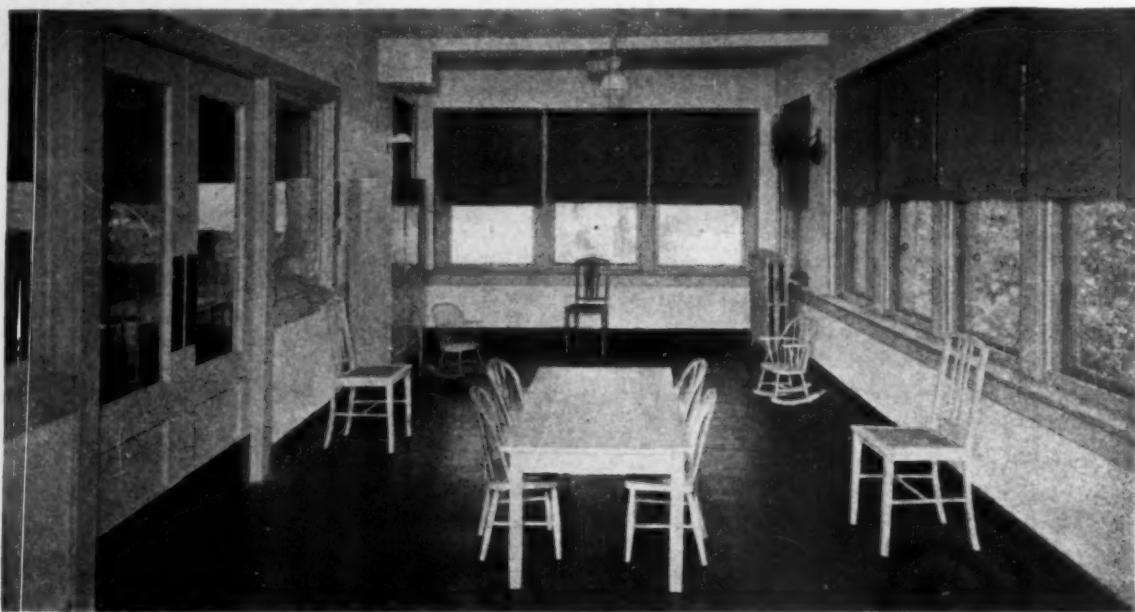
"When the permit form is not modified in any way, the word "body" includes chest and abdomen only. Special permission must be obtained for the examination of the brain and spinal cord and in such cases the words "brain" and "spinal cord" must be inserted. The same applies to the neck organs. At least two hours time must be allowed for proper performance of an autopsy, more is preferable. The pathological department should be notified at the earliest possible moment when an autopsy is pending. On many occasions undertakers have been caused a lengthy delay because the person responsible had not made out the death certificate and no one could be found who would sign it. Undertakers must not be unnecessarily antagonized. A coroner's case is to be reported to his office even if the death occurs a long time after the original injury."

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#### OFFERS TO HELP BUILD HOSPITAL IN RURAL SECTION

With the purpose of improving rural medical nursing and hospital care, the Commonwealth Fund of New York, is offering to assist in the building of one hospital in a rural section. Certain conditions are laid down governing the distance from existing hospitals, number of physicians for staffing the hospital, character of highways and transportation lines, willingness and ability of the community to defray deficits from operation. The fund offers to pay two-thirds of the cost of construction and equipment.

If the experience in building one such hospital seems to warrant an extension of the program, the fund will consider making a like offer to other districts.



## *Helping Children Get Well*

*Top, one of the solariums at the Children's Hospital, Birmingham, Ala.*

*Left, bedtime story hour in the nursery of a New York hospital*

*Below, the play room in the William J. Hicks Memorial Hospital, Oxford Orphanage, Oxford, N. C.*



## THE IMPORTANCE OF PROTECTING PATIENTS' CLOTHES\*

By C. W. Munger, M.D., Director, and B. M. Bamber, R.N., Directress of Nurses, Grasslands Hospital, Valhalla, N. Y.

**C**ONSCIENTIOUS handling of the patient's property is essential. Inadequate facilities or lack of system for this work will almost surely breed trouble for the hospital. The writers have encountered examples of such trouble in the institutions with which they have been associated. They are inclined to believe that such instances occur more often in the larger hospitals because of a lack of personal interest in the patient on the part of the employees who handle property. They have recently studied quite thoroughly the published facts concerning methods used in other hospitals and profiting by the advice contained therein, and by their past experience and mistakes have devised a system for their own hospital.

This 500 bed county hospital caters exclusively to free and part-pay patients. There are no private rooms or private wards. Practically all medical services are represented. The system of handling clothing is the same for medical, surgical, children's, and obstetrical cases. Special provisions are necessary for the tuberculosis, venereal, and contagious wards. Unusual care is exercised in connection with property for psychopathic patients because of the danger of self-injury.

The system outlined here has been devised to suit conditions in this particular hospital. We believe the fundamental principles are sound, but judge that changes in detail might be necessary if it were applied elsewhere. The size and type of institution are factors to be considered.

At what objectives should a clothes room system aim? The main ones are detailed in the following paragraphs:

(1) *Prevention of loss.* It is true that our patients receive, without charge, treatment far more valuable than any property that might be lost. We believe, however, that it is unjust to take advantage of this fact, and in case of actual loss, the hospital replaces every article or pays for it at a just figure.

(2) *Removal of Pathogenic Bacteria*

This is absolutely necessary, although drastic methods are not always required. Air and sunlight are very valuable. We also use a hot-air cabinet which is described below.

(3) *Removal of Pediculi and Other Vermin*

Chemicals such as formaldehyd are of no value. Steam sterilization is the surest method.

(4) *Removal of Dirt*

Soiled clothing should be dry-cleaned or washed.

(5) *Restoration*

Clothes should be mended and pressed before they are put in storage. Clothing unfit for use should be replaced from the social service department's stock, so that a presentable outfit may be available for the patient upon discharge.

(6) *Prevention of Moths.* If necessary, rigorous measures must be used to prevent moths; careful cleaning and pressing of clothing before storage, plus a good spray or powder, will usually suffice.

(7) *Protection from Dust.* It is obviously necessary to protect the clothing from dust.

Centralization of storage is necessary for good results. It is not wise, unless the hospital is very



Where delousing is necessary a hot air cabinet is needed. It can also be used for infected clothing that will not stand steam sterilization.

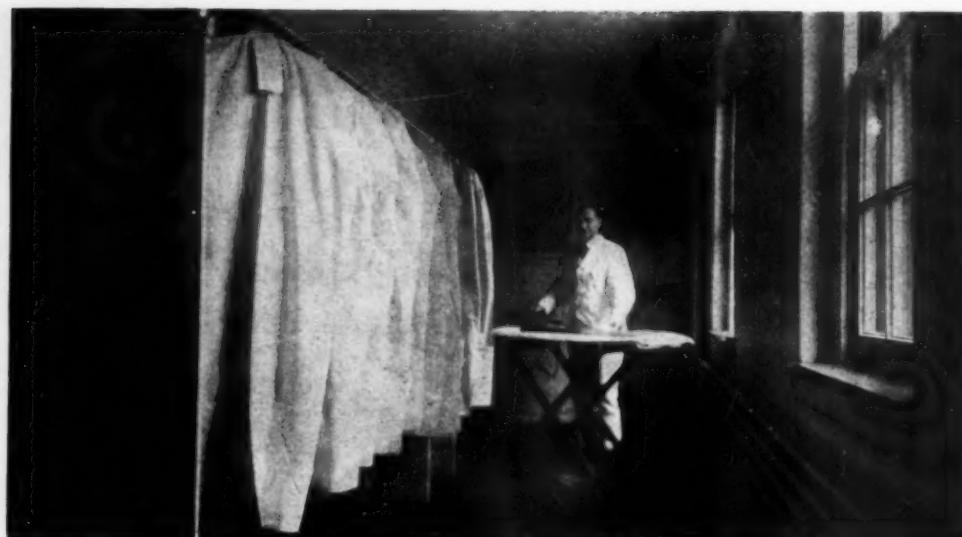
\*This is the third of three articles on the care of patients' clothing. The first and second articles appeared in the June and September issues.

large or has widely separated buildings, to have more than one clothes room. There can be no justification for having separate storage facilities for clothing from cases of communicable disease. Such clothes, properly handled, are not a source of danger. To maintain a separate clothes room is to invite carelessness.

The system of caring for clothes and valuables should provide for complete check-up when necessary. If articles are lost it must be possible to ascertain at once what person has been careless or dishonest.

If a hospital has over five public ward admissions daily, it is probably necessary to have a full-time clothes room attendant. Delegation of this work to several different persons who have other major duties will cause confusion. Immediate checking and disposition of all articles is desirable. It is necessary, however, for the night supervisor to see that property from night admissions is deposited in a locked cabinet.

Any system will fail if the "higher ups"—superintendent of hospital or directress of nurses



The clothes room attendant at work. Note the muslin clothes covers with pockets for shoes and small articles the patient brings with him to the hospital.

—do not frequently check its close observance.

Belongings of deceased patients are often the source of dispute. Relatives at times insist that all of the property has not been returned. A property list signed by the patient upon admission serves as an effective answer. Most hospitals deliver property to a reputable undertaker when he calls for the body, but he should invariably sign an itemized receipt. If especially valuable articles are in the care of the hospital, it is wiser to insist upon a personal call from the nearest relative who should identify himself and sign a receipt.

The following is a brief outline for the care of the patients' valuables and clothing. Much more detailed instructions must be given to attendants on duty both in the admitting department and clothes room.

The clothes room is open for receipt and delivery of clothing from 7:00 a. m. to 7:00 p. m. and requires the entire time of one person, with relief for time off duty and meals. The admitting room attendants supply this relief, and the handling of clothing and valuables is, therefore, limited almost entirely to the persons on duty in these two departments.

All patients, admitted

#### CLOTHING LIST

Name	Smith - Nellie A	Ward	32-40	Date
X BATHROBE	CORSET	✓ NIGHT GOWN (2)	SUSPENDERS	August 6 <sup>th</sup> 1921
BELT	CORSET COVER	OVERCOAT	SWEATER	
BLANKET	X CRUTCHES	PAJAMA COAT	TIE	
BONNET	✓ DRAWERS	PAJAMA PANTS	TROUSERS	
✓ BRASSIERE	✓ DRESS	✓ PETTICOAT	UMBRELLA	
CANE	GARTERS	RUBBERS	UNDERDRAWERS	
CAP	GLOVES	SHAWL	UNDERSHIRT	
CAPE	HAND BAG	✓ SHIRT	UNION SUIT	
✓ CHEMISE	HANDKERCHIEF	✓ SHOES (low)	✓ VALISE	
✓ COAT	✓ HAT	SKIRT	VEIL	
COLLAR	✓ HOSE	SUIT CASE	VEST	
			WAIST	

Articles marked X taken to ward at patient's risk.

I hereby certify that the above list is correct.

Received clothing on above list

*Nellie A. Smith*  
Signature of Patient

*Nellie A. Smith*  
Signature of Patient

*M. Brown*  
Signature of Nurse

during the day, except those for contagious wards, enter the hospital through the admitting department.

Clothing and valuables are carefully listed on clothes card by admitting room attendant and the signature of the patient or the patient's friend is obtained.

Valuables are placed in a special envelope; the contents are listed on the outside of the envelope, which is taken at once to the business office. The

Articles that would be damaged by steam sterilization are put in a bag marked with a red tag and sent to the clothes room.

If the patient is too ill to be undressed in the admitting room, the attendant on duty follows the patient to the ward, makes out a clothes card in the usual manner, secures patient's signature, and takes valuables and clothing to admitting room. Day attendant in admitting room takes care of this clothing at once.

Night supervisor is responsible for the proper listing and care of clothing and valuables of patients admitted at night. Such clothing and valuables are locked up in a special locker near the admitting room. The day attendant in the admitting room takes care of this clothing the next morning.

#### Contagious Ward Procedure

We endeavor to have patients admitted to the contagious wards in hospital clothing, and a bundle containing bathrobe, underwear, and stockings is sent with the ambulance when it goes for a patient for this department.

When patients are wearing their own clothing on admission, it is cared for as follows: Underclothing for sterilization is put in bag, marked with red tag showing list of articles in bag and sent to sterilizer.

A second red tag giving complete list of patient's clothing is made out and checked to show clothes sent to sterilization.

Outside clothing, such as dresses, coats, trousers, hats, shoes are sunned and aired for twelve hours and then sent to clothes room. A red tag made out at the time of the patient's admission is sent with this clothing.

When clothing is received from the admitting room or contagious department, lists are carefully checked and verified.

Clothing in good condition is hung on a hanger covered with a muslin cover, and hung in the proper compartment.

Soiled underclothing is sent to the laundry to be washed and a record of such articles is entered in the laundry book. Clothing returned from the laundry is checked off in the laundry book and hung in the proper compartment with the remainder of the patient's clothing.

Coats, trousers and dresses that are soiled or wrinkled are sponged and pressed before being put away on a hanger.

Infected clothing received from the admitting room is put in a hot cabinet and exposed to a temperature of 150° F. for 30 minutes. At the end of this period the clothing is sunned and aired and put away in the proper compartment.

<b>Clean Clothing For Storage</b>	
Ward <u>32 - 34</u>	Date <u>Aug. 6 '25</u>
Name <u>Smith, Willie A.</u>	
Bathrobe	Overcoat
Belt	Pajama Coat
Blanket	Pajama Pants
Bonnet	Petticoat
Brassiere	Rubbers
Cane	Shawl
Cap	Shirt
Cape	Shoes (low)
Chemise	Skirt
Coat	Suit Case
Collar	Suspenders
Corset	Sweater
Corset Cover	Tie
Crutches	Trousers
Drawers	Umbrella
Dress	Underdrawers
Garters	Under Shirt
Gloves	Union Suit
Hand Bag	Valise
Handkerchief	Veil
Hat	Vest
Hose	Waist
Night Gown(2)	

J. Brown

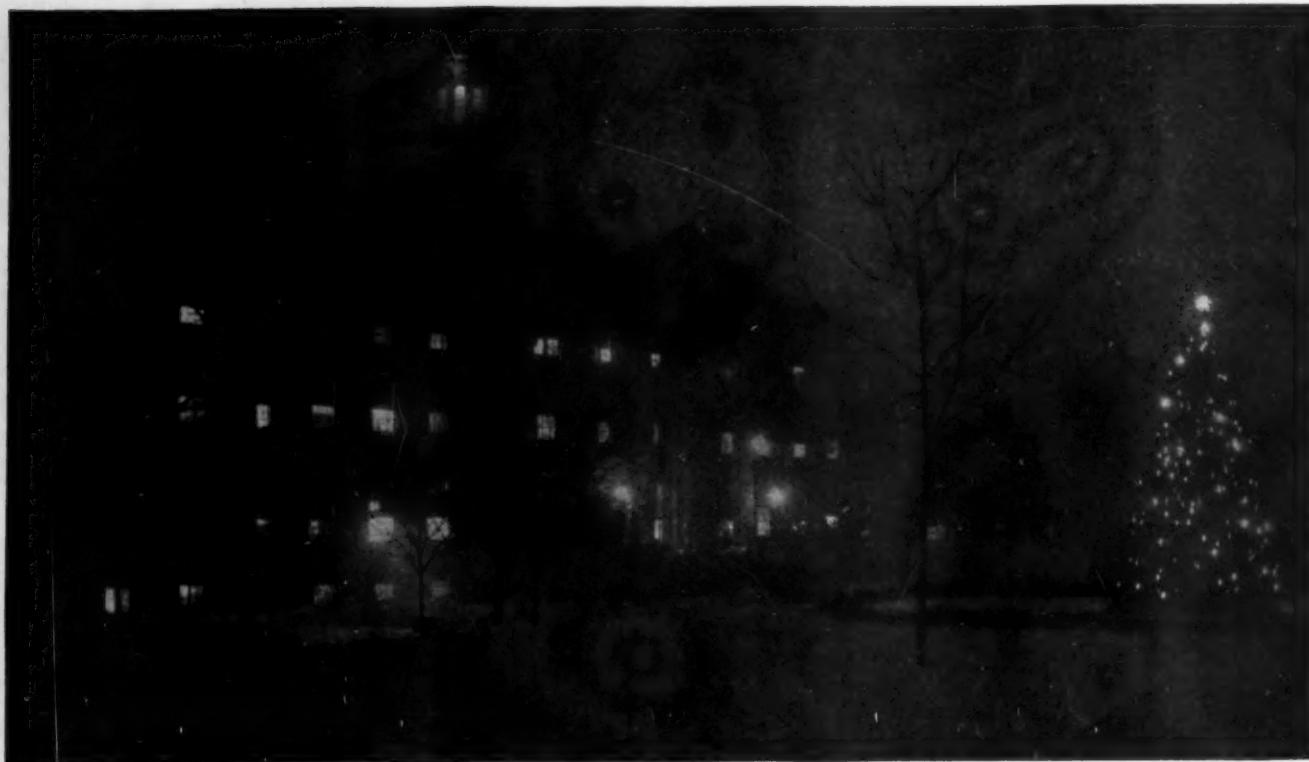
NURS\*

Clean clothing is checked for storage with the above list.

bookkeeper verifies the list of valuables and signs the clothes card, which is returned to the clothes room.

Clothing from non-infectious cases and free from vermin is placed in a basket, tagged with a white clothes tag, and sent to the clothes room.

Infected or vermin infested clothing, except such articles as would be ruined by steam sterilization, is put in a bag, tagged with a red clothes tag, and sent direct to steam sterilization. A duplicate red tag, checked "V" to show list of such clothing, is sent to the clothes room.



Christmas Eve at Walter Reed General Hospital.

## WHAT CHRISTMAS MEANS IN THE HOSPITAL

**I**N every land that Christianity has penetrated, in the far reaches of the North and the torrid lands of the South, in the cities and in the hamlets, Christmas comes as a sort of a milestone in our lives when we pause to pay tribute to the Founder of all Christianity, when we regard our fellow men with a more kindly feeling and when we take a mental inventory of our own lives. It has become the season when we truly practice the biblical prompting that it is more blessed to give than receive and in following this most noble thought we have naturally come to feel that the poor, the sick and the helpless should be remembered first.

There is an indefinable something that tugs at our heartstrings when we are able to bring joy to little children at this time of the year. That tender feeling we always have toward the very young is intensified by the thoughts of the Babe of Bethlehem in a manger many centuries ago. When those children have crooked little limbs or backs or some other malformation and must be confined in hospitals, we naturally feel that all we can do to make them happy is hardly recompense enough for their suffering.

Christmas is a memorable day in the children's hospitals throughout the land. Many hours of careful preparation are given toward the one short hour when the children will awake and find

the brilliantly trimmed tree, the stuffed stockings and the fulfilled promises of Santa Claus. The sharp pangs of pain are forgotten momentarily and little hearts—long weary—become happy and gay.

No less are the preparations in the hospitals for the mentally ill. Attendants and patients alike join in the festivities and in some cases the entire week is given over to festivities. In the hospitals for acute diseases as much as possible is done at Christmas time, but it is among the children and those whose mental faculties are impaired that the greater spirit prevails.

In memory of James Whitcomb Riley, whose verses for and about children will live forever, a splendid hospital for children has been built in Indianapolis. Perhaps it is most fitting that Christmas at that hospital should first be described. Harriet E. Davis, instructor at the training school for nurses, Indiana University, has recorded the festivities in that hospital in a style worthy of the great poet himself and we have the privilege to present it herewith:

\* \* \* \*

### Christmas Day at Riley Hospital

"It came upon a midnight clear  
That glorious song of old  
From angels bending near the earth  
To touch their harps of gold."

Dozens of sleepy, little heads lifted suddenly from their pillows and drowsy eyes opened in awed surprise as the vibrant tones of the old Christmas carols broke the solemn, dim stillness of the morning. Down the long corridors, in and out of each ward a long double line of nurses marched slowly to the rhythm of their songs. The dim night lights threw a soft glow over the radiant faces of the long procession from the stately superintendent down to the last thrilled, starry-eyed, pink probationer. And thus Christmas morning broke in James Whitcomb Riley Hospital for Children.

As the voices of the carolers died away the soft, red, green and golden glow of the twinkly little Christmas tree lights flashed on in each ward, reflected by a thousand sparkling ornaments and myriad tinsel strands. A breathless hush followed only for a moment, broken suddenly by a delightful clamor of shrieks and squeals. In that deep, inexplicable way in which such things have come about on Christmas Eve since time immemorial a gift and a gay net stocking full of nuts and candies and trinkets had appeared on each child's bed. Moreover, the dim light threw into curious relief around the Christmas trees interesting collections of boxes and packages, and gay tribes of calico cats and gingham dogs and cretonne elephants and brown felt monkeys that hung with cheerful grinning suspense from the branches.

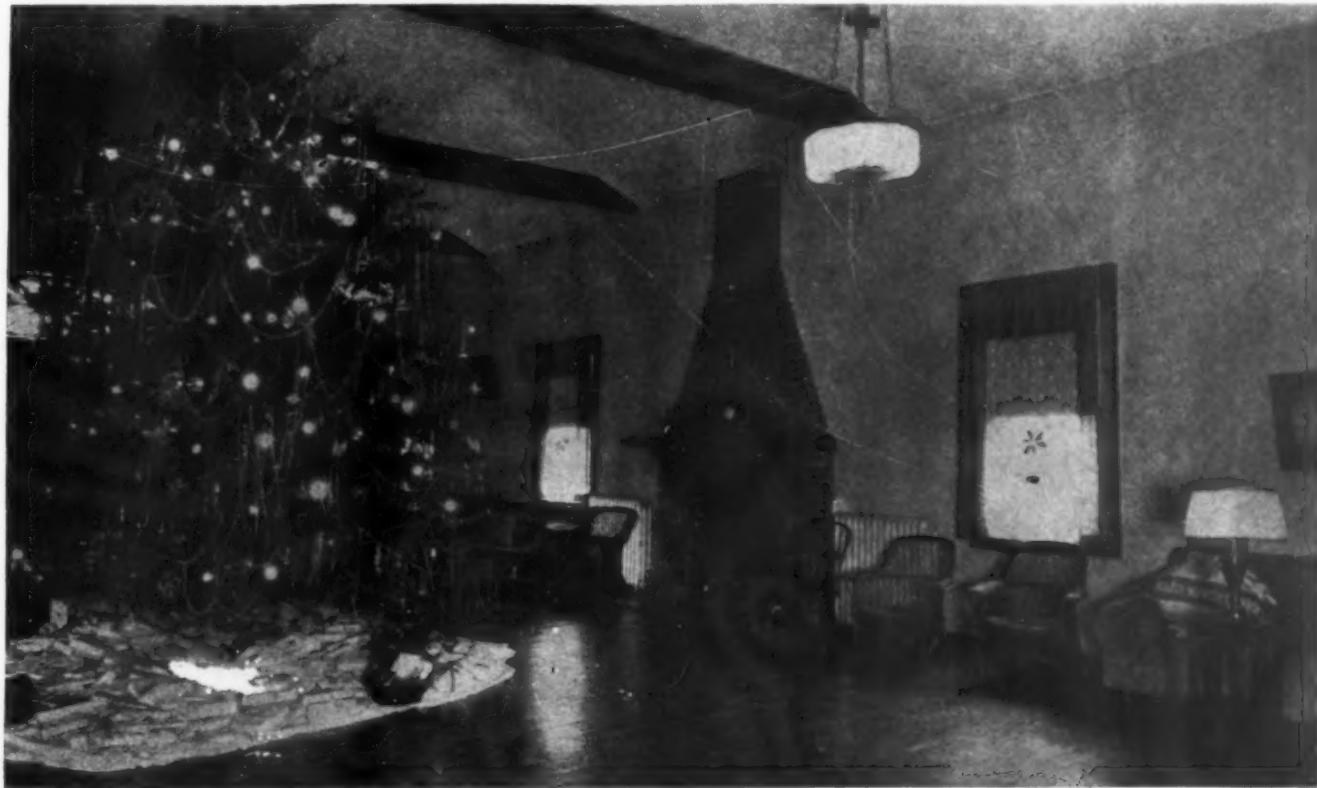
The patient night nurses alone know with what

cunning persuasion excited little heads were held still to be brushed and beaming faces washed for breakfast. But it was somehow accomplished 'mid squeals of "How far will yours go when it's wound up, Joe?"' and "Lizbeth, can yours say 'Mamma'? Mine does." Even the babies down in ward "B" caught the spirit and whanged their new rattles gleefully against the crib sides or cheerfully attempted to pluck the eyes from the new woolly animals.

Soon a busy stir and soft shuffling of feet around the head nurses' desks announced the arrival of the day nurses, and there was a shrill, confused chorus of "Merry Christmas, Merry Christmas, oh come see what he brought me!"

The day wore on made bright and happy by the loving thoughtfulness and generosity of many organizations and individuals of Indianapolis and throughout the state. Breakfasts were coaxed down; baths and necessary treatments were somehow given; beds and tables straightened; and occasional minor rebellions at being interrupted for such stupid things as tooth brushing were gently quelled. Dinner trays gay with Christmas delicacies coaxed lagging appetites at noon.

After "quiet hour" in the afternoon a pleasantly rotund Santa frisked from ward to ward leaving in his wake ecstatic commotion as he distributed gifts which kept piling in from mysterious sources. Choirs from various churches and bands of carolers appeared from time to time



A huge Christmas tree laden with gifts is the center of festivities in the nurses' hut at Walter Reed Hospital.

to sing the sweet old Christmas songs which never fail to thrill. A fatherly rector of one of the Episcopal churches gathered groups about him and told stories. The "up" children scampering about on crutches and in wheel chairs collected in little knots from time to time to try out new games or puzzles or mechanical toys. The "bed" children were happily content with dolls and books and paints and pencils and modeling clay. A moving picture film provided an hour's breathless entertainment for the children who could be moved into one ward.

Visitors came and went. In the gaily decorated reception rooms and halls down stairs impatient parents and friends paced about awaiting their turn to visit their little ones without whom the family circle seemed desolately incomplete on Christmas day. The streets before the hospital were lined with shabby, mud bespattered vehicles; shaky old Fords with tattered bed quilts thrown solicitously over their radiators; cars with flapping side curtains carefully buttoned on to help keep out the biting, zero air. For many of these parents had driven long distances for short, jealous glimpses at peace, for they had found them tenderly cared for and happier and more content than they could have been made under the circumstances at their own firesides.

The early winter twilight fell. Christmas tree lights flickered on again and bed time preparations went on. Delicate little bodies and active little brains were overcome with happy weariness and they fell into blissful sleep and Christmas Day closed for the children.

#### Joy Brought to Crippled Children

For those of us who were privileged to look in upon the scene that day, there remains but one impression—we saw not crippled and malformed bodies and pinched faces and spastic limbs; we saw radiant happiness and cheer and we felt the uplift that comes so strongly with the conviction that after all love and good will abound in the world.

Somewhere I have read the old proverb "We go down to our graves carrying in our hands only that which we have given away." If this be true, then the people of Indianapolis and Indiana who have given so generously and whole heartedly to Riley Hospital and to the Riley children will approach the hereafter with a goodly load.

\* \* \*

From another part of the country—Boston—comes a Christmas story equally beautiful. It is called "Angels—Trees—and Stockings" and is by Margaret Stanger of The Children's Hospital, Boston, Mass.

Morning rounds were being made on the orthopedic ward. From the last bed, two large brown eyes were anxiously watching the group of physicians, as they went from bed to bed. It was almost Christmas and today would decide how many of the little patients were to be discharged and how many were to stay in the hospital.

Tony Napolitano was waiting for the verdict, and praying that he might stay. Luigi Papas, a little boy in Tony's room at school, had been here in the hospital the year before and Tony well remembered how Luigi had stood by teacher on his crutches, and with shining eyes had told the story of his Christmas in the hospital; of "Angels that came in the night, and trees with stars on and stockings hanging on the bed empty as anything at night, but in the morning when you woke up—Oh Gee!" Yes, Tony remembered it—angels, trees and stockings. And he might see it all this year if the doctors said so. He waited breathlessly.

#### Tony's First Real Christmas

It had not seemed strange to Tony that Christmas had never come to him at home. "There wasn't room," he reflected, "not with the Mama and the Papa and the little grandmother, besides the six brothers and sisters and the baby, in the two small rooms that were home." He just wished Salvatore, the brother who coughed so much, might be here too.

The doctors had reached his bed. "Hello Tony. How about it? Guess we'll have to keep you a while yet."

"Yes, please," answered Tony in his politest manner. And the doctors went on leaving Tony almost bursting with joy.

As soon as the doctors had left the ward, two men appeared, carrying real trees. Tony had seen trees like these down by the markets. He watched the men set them up, one at each end of the ward. One of them was right close to Tony. It smelled so good. All the time he was eating his dinner he kept his eyes on the tree and very reluctantly went to sleep at rest hour when the shades were pulled after dinner.

After the naps that afternoon, four or five nurses came in, two of them carrying a tiny organ which they placed in the center of the ward. One of the nurses sat down and began to play the organ. "How many know this song?" asked one of the nurses. "I do,—I do," came from several beds. "I do," said Tony, for it was "Silent Night" and he had learned it in school. The next one he knew too,—"It Came Upon the Midnight Clear." And the children chimed in and sang the carols.

Early the next morning Tony awoke and looked

immediately for the tree. He rubbed his eyes and blinked and looked again. What had happened? It was covered with sparkling snow, shiny gold and silver things, and tiny colored lights. Up at the very top was a wonderful star. The nurses, watching the faces of the children as one by one they saw the tree, were doubly glad that they had worked so fast and so quietly in the night, decorating the trees without waking a child.

After breakfast, two nurses all in white came down the ward, stopping at each bed to ask what its occupant wanted from Santa Claus.

"Well Tony, what shall we ask Santa to bring to you?"

"Pointing to the tree, where on the branch

listened. He could see no one but somewhere they were singing "Silent Night." "Who is it?" whispered the boy in the next bed.

"Angels," answered Tony, "don't make a noise."

Song after song sang the angels, who were the boys from the Trinity choir, singing unseen the world's sweetest music—"that glorious song of old," and "praises to the new-born King." After they had stopped, a nurse came in and suggested that the children sing for them, and they sang their carols, Tony with all his heart and soul pouring forth in the music. By that time it was light and—"Look at my stocking," screamed David. "And mine,—and mine." Without a word Tony looked at his. It was bulging and



The ward that received the prize for the most effective Christmas decorations at the Walter Reed Hospital.

nearest his bed hung a tiny golden trumpet suspended by a golden thread, he answered, "Please a gold horn like that one," and after a moment he added, "and please maybe one to take home to Salvatore." Not another wish could they get from him.

What a day he spent—practicing carols, discovering each time he looked a new ornament on the tree. And then just before bed time a huge red stocking was given to him. Each child had one and was told to hang it to the head of the bed by the string at the top of the stocking. As Tony was flat on his back strapped to the frame that was to make him straight, and could not reach up to hang his the nurse did it for him.

Tony was tired and slept soundly. Before it was light out of doors he was wakened by sounds of the sweetest music he had ever heard. "Angels," thought Tony at once and eagerly he

knobby and something was sticking out at the top. The nurse took it down for him and laid it beside him where he could unload it.

The white package at the top had two of the tiny golden horns that gave forth a soft note when blown. A large horn, red and white, came next. A pair of red mittens, a game, which he promptly put under his pillow to take home,—oranges, apples, nuts, a set of soldiers, two books, a pencil box,—the shouts of the other children caused him to look up, and there coming right down the center of the ward was Santa Claus himself. He stopped at Tony's bed, shook hands with him, called him by name, and took out of his pack on his back, a gun, another book and a beautiful boat, all of which he put on Tony's bed. Tony's eyes were wide with wonder at it all. "How about a song?" suggested the nurse, and with his eyes fastened on Santa's face, Tony sang a carol.

The packages which had mysteriously appeared around the base of the tree were distributed, each child receiving something. The dinner trays were resplendent with Christmas napkins and red candles. There was ice cream and peppermint hearts. It seemed to Tony that he could not look enough at everything. Visitors came and the carols were sung so often that he hardly had time to examine his own lovely things. After supper he lay with a golden horn in each hand thinking,—“Angels, trees, stockings. Angels,—”

\* \* \*

“Christmas is a happy time at the New York Children’s Hospital on Randall’s Island,” writes C. G. McGaffin, medical superintendent. “The children begin to look forward to the celebration months before and talk about it for months after.

“Each child is asked what he or she wishes for Christmas and, as far as possible, these requests are granted. Many friends of the hospital remember the children and each one is well taken care of. On Christmas morning Santa Claus goes about each ward and the children flock about him in droves, looking up at him reverently.

Thanksgiving Day is hardly gone before preparations begin at the Yankton State Hospital for the celebration of Christmas. The different wards are decorated with gay garlands of Christmas colors and a friendly rivalry ensues as to which ward is the most tastefully decorated.

A full week of entertainment is enjoyed at Yankton and dances, entertainments, distributions of gifts, motion picture shows and dinners keep the patients and employees well occupied.

“The midnight Mass, with its accompanying traditional hymns, is, of course, the central feature,” writes Sister Michaella, Superior at the St. Vincent’s Infirmary, Little Rock, Ark.” Every patient who is able to do so attends. The wards and halls are appropriately decorated and the nurses have a big tree in their home.”

#### Employees Entertained at Nurses’ Home

On Christmas Eve at the Iowa Lutheran Hospital, Des Moines, Iowa, everyone gathers for the Christmas party. This party is held in the nurses’ home and all resident employees of the institution are invited. This includes the superintendent of the hospital, the superintendent of nurses, such members of the office force who live at the institution, maids, and the janitors. The first part of the evening is spent in listening to a Christmas program. Games are played and then refreshments are served. The superintendent reads the Christmas story as it is recorded in Holy Scripture and the party ends with the singing of “Silent Night.”

In the morning the nurses all gather in the chapel and start out on a processional through the corridors of the hospital singing carols.

The Junior Auxilliary of the Children’s Memorial Hospital, Chicago, plan and take care of the celebration at this hospital and, according to advices, do a thorough job. The children are encouraged to write letters to Santa Claus in which they may ask for three gifts and a “surprise. These letters are collected and handed to the members of the junior auxiliary and they, in turn, pass them on to their friends who respond most generously so that each child actually receives the gifts for which he or she asked.

#### Receive Gifts from Donor of Home

Sister Catherine, Sister Superior at St. Mary’s Free Hospital for Children, New York, states that on Christmas Eve the hospital is decorated with evergreens and to add a touch of brightness, red bells are hung from the electric fixtures and sprays of holly are attached to each crib.

The nurses have a party at which gifts are exchanged and each nurse receives a gift from the donor of the nurses’ home and in addition a five dollar bill from two other friends.

The children’s stockings are filled and tied to the foot of each crib. In the morning they are opened to the delight of the little sufferers.

On the Sunday preceding Christmas a special musical program is given by a choir of fifty patients at the State Hospital for Mental Diseases, Howard, R. I. Both the Roman Catholic and Protestant services are given. There is also at this institution a week of festivities consisting of motion pictures, dances and Christmas music. One of the features of the week is a costume ball when about four hundred patients are in costume.

In Australia the absence of snow and cold weather does not hinder the nurses and patients of the Sydney Hospital from entering into the spirit of the season, according to V. H. Kellick. In China, Clara Kuo Ellen Wang writes that the celebration in the Sleeper Davis Memorial Hospital, Peking, is an affair long to be remembered despite the fact that “China has had famine, flood and war during these last few years.”

So it would seem that everywhere Christmas brings cheer to those who need it most and each year efforts are increased to see that patients are given even more happiness. Space does not permit a recital of all the celebrations that will take place, but with these few examples it can be readily seen that nurses and the other personnel of hospitals are carrying onward the Christmas spirit.

NOTES ON  
ADMINISTRATIVE  
PROCEDURES

ROUTINE FOR ADMITTING AND  
DISCHARGING PATIENTS

**F**EW other phases of hospital work can be so productive of friendliness and good will as that of admission. What to us is a commonplace is to the patient a momentous occasion, a red-letter day. For the great majority of people, admission means entrance to an entirely unfamiliar institution. They know hospitals only by reputation or by remembrance of the aseptic odors noticed during their infrequent visits. To many of them, abnormal in mind and sensitive of nerves, the immediate future is filled with dark forebodings.

Since this is true with a large percentage of all hospital patients, it should be the duty of the admitting officer to make everything as easy and matter-of-fact as possible. Sympathetic understanding of the patient's difficulties will do much to create in the patient an attitude of receptivity and willingness for the necessary steps that must follow. Such an attitude will be of great help to both hospital and patient.

Psychological factors play an important part in the speed with which health is restored. Given confidence in the attending physician and a feeling of friendliness and gratitude toward the institution, the patient's recovery is more definitely assured or expedited. On the contrary, an attitude of unfriendliness toward the hospital will mar the confidence the patient places in the physician and will tend to hamper the progress of recovery.

Too often, under the stress of many duties and the need for haste, the admitting officer inclines to brusqueness. This gives the patient the impression that the institution is heartless and cold-blooded—too big to permit of sympathy and understanding. Thus are friendliness and good will destroyed, and confidence undermined.

The creation of amity does not lie solely with the admitting officer, however. Much of the good work of a considerate admitting officer can be nullified if the receiving nurse is devoid of cordiality and sympathetic understanding. With the receiving nurse rests the responsibility for the initial steps in therapy and if she, in any way, assumes a dictatorial attitude or fails to consider

the patient as a guest, her actions will give rise to antagonism—an attitude detrimental to the progress of the patient.

Broad acquaintance with the hospital field reveals a wide range of requirements in the professional routine of admission. Where one hospital will have an admitting practice that is simplicity itself, another hospital will employ a long and rather involved process of examination, routine analysis and diagnosis. Since hospitals of the same character differ widely in their admission routine, it is believed that the presentation of a study of admission routine will be both timely and valuable. The following are admission and discharging routine incorporating features found in the standing orders of a number of efficiently administered hospitals. This composite, or cross-section, is published for the purpose of comparison:

**Admission Routine**

1.—The admitting officer shall immediately notify the chief intern of the arrival of patients. (In large, multiple-floored hospitals, where pages are employed to escort the patients to their rooms or ward-beds, the admitting officer notifies the floor nurse of the arrival of the patient, in addition to the personal notification of the page. This procedure double-checks the patient into service and eliminates the possibility of the busy floor nurse overlooking the arrival of the patient.)

2.—Upon admission, the attending nurse takes temperature, pulse and respiration and notes the general condition of the patient—imparting such information to the chief intern immediately. Enters T. P. R., and orders for diet, and routine urinalysis on chart. A bath is then administered, after which the patient is put to bed. For temperature below 100, a cleansing tub bath is given unless pulse and other conditions contra-indicate. For temperature above 100, the patient shall be put into bed, protected by rubber sheet and blanket, and given cleansing sponge bath. Hair shampoo or exterminator shall be given every patient. The hair of female patients, unless bobbed, must be parted in the middle and braided firmly in two braids.

3.—Clothes must be listed, tagged and put into the compartment or locker corresponding to the ward bed, and the clothes list signed and dated by nurse admitting the patient. The door or the locker or clothes closet must always be kept locked and the key left at the head nurse's desk.

4.—Money or valuables must be taken to the office, a receipt obtained and given to the patient. The admitting nurse is held accountable for loss of any money or valuables not so disposed of.

5.—All patients under 14 years of age, and all adult ambulance cases, shall have the admission temperature taken by the rectum. All ambulatory patients over 14 years of age shall have the admission temperature taken by the mouth. A rectal temperature is taken of all patients as soon as put to bed.

6.—The ward physician shall take nose and throat cultures of all patients under 14 years of age, and vaginal smears from all female patients under 14 years of age. Routine urinalysis will be made for all patients, preferably from A. M. specimens.

7.—All minor patients shall be weighed upon admission;

the children over two years of age being weighed once a week thereafter, and those under two years of age, each morning thereafter. All ambulatory adult patients shall be weighed upon admission and once a week thereafter.

8.—Upon admission of any patient unable to speak for himself, that is, baby, unconscious person or foreigner, the nurse shall detain any person who accompanies the patient until the chief intern can interview him or her. (In large institutions, where emergency cases are frequent, the emergency physician receives this proxy information.)

9.—All free, or ward patients shall be required to gain entrance to the hospital only through the "examining room," where each patient will be given a routine urinalysis, Wassermann, and be submitted to a thorough examination for contagious or infectious disease, and for vermin or lice.

10.—In the event the case is operative, the intern will prepare all male patients, the nurse preparing all female patients.

#### Discharging Routine

1.—No patient may leave the hospital without the doctor's written order.

2.—Admission card must be taken by the nurse to the office before the patient leaves the hospital.

3.—The chart must be removed from the cover, any blank sheets removed, the date of discharge filled out, and the chart then bound in proper form and sent down with the directory the following morning.

4.—All clothes listed must be accounted for and the clothes book checked with the signature of the nurse and the date of discharge.

5.—Mattresses and pillows must be thoroughly brushed with a damp whiskbroom. Rubber sheets must be scrubbed with warm soap and water. The bed must be washed with disinfectant after it has been thoroughly cleansed with soap and water. After pus or other infectious disease, the mattresses and pillows must be put into a bag provided for that purpose and taken to the roof for airing and sunshine.

6.—Bedside tables must be thoroughly washed with disinfectant inside and out, and fresh paper put in the drawers.

7.—Special nurses must leave their rooms ready for occupancy (except cleaning).

8.—All letters and packages sent to the floor for patients who have left the hospital are to be returned to the information desk immediately. Any article left by the patient is to be taken to the assistant superintendent's office, tagged with the name of the patient and room number.

9.—When a discharge is written for the patient who has had radium treatment, the nurse in charge shall call the intern to ascertain if the radium has been removed.

#### NEGATIVE NOTICES

It is a well known fact that certain words produce a negative reaction. "Complaints" is such a word. No one wants to suggest that there might be grounds for a complaint, or even dissatisfaction. For this reason the superintendent of a large Massachusetts hospital removed the word COMPLAINTS from one of the windows in the front office and replaced it with the word ADJUSTMENTS. This word is also more appropriate, because it expresses more accurately the true function of that department.

On the other hand, the words complaints only encourages the fault finders who are in every hospital.

#### ARRANGING EMPLOYEES' HOLIDAYS

THE nature of hospital work precludes any general observance of holidays, but every effort should be made to grant holiday privileges to as many of the staff and employees as possible. However, no department head or other responsible person should at any time permit so many employees to be off duty on any given holiday as to interfere with the proper care of patients.

The holidays universally recognized by the majority of hospitals include New Year's Day, Washington's Birthday, Memorial Day, Independence Day, Labor Day, Election Day, Thanksgiving Day and Christmas Day, and on these the dispensary and laboratories are closed and all other departments are conducted by a minimum staff.

Other holidays are usually recognized only by special dispensation from the administrative officer or from the executive committee of the board of directors.

#### How Vacations Are Determined

Vacation periods are usually restricted to the weeks between May 1, and September 30, and should be arranged in each department so that they will interfere as little as possible with the regular work.

January 1 is ordinarily set as the date used for the computation of vacation time.

Department heads and their assistants on full time are given vacations of four weeks, the time for each being approved by the superintendent.

Members of the resident staff receive two weeks' vacation each six months in accordance with established schedule kept on file in the superintendent's office.

Graduate nurses not directly employed in care of patients are allowed vacations of two weeks for each twelve months' employment.

All employees not specifically mentioned, who have been with the institution less than one year, receive one day for each month of employment; those who have been employed for one year, but less than two years, receive two weeks; those who have been employed more than two years will receive two weeks and an additional day for each additional year, except that no vacation should be longer than four weeks' duration, regardless of length of service.

In addition to the above vacations, leave of absence, with or without pay, should be granted only in special cases. The employment of relief workers should never be permitted, as the other personnel in the same department should be able to carry on during the vacation period.

Any request for change in this schedule should be made in writing before April 15, so it may be referred to the superintendent. By that date all department heads should have prepared and filed in the superintendent's office a schedule of vacations, so that every employee may receive his or her salary in advance for that period.

### MAKING THE DEPARTMENT HEAD CONFERENCE CONSTRUCTIVE

**D**R. ERNST P. BOAS, medical director, Montefiore Hospital for Chronic Diseases, New York, brings to our attention a procedure that has proved constructive and interesting.

At his hospital weekly conferences are held at which all department heads are required to attend. At these meetings the director brings up for discussion any subject of importance, but each department head is requested to bring to the attention of all any topic that requires the co-operation of two or more departments. This is followed by free, round-table discussions.

Minutes are read at the beginning of every meeting to serve as a check on the completion of the suggested requirements. At the close of each year, all important topics are brought again to the attention of the department heads to the end that chronic defects may be recognized and corrected.

The following copy of the minutes of one meeting indicates the general range and scope of the discussion.

#### House Conference Held Wednesday, April 22, 1925

PRESENT: Dr. Boas; Messrs. Goodman, Goodrich, Goodfriend and Ritschel; Mesdames Constantine, Murphy and Keegan.

Mr. Goodrich mentioned that the electric outlets in the nurses' and doctors' quarters had been installed.

Dr. Boas read the expenditure report for the month of March and called attention to several items exceeding the limits set by the budget.

Miss Murphy stated that she would require closed containers for the transportation of food for the Schiff pavilion. Mr. Goodfriend was requested to give this matter his attention. She also mentioned that the dining room tables needed refinishing.

Mr. Ritschel requested a number of additional chairs for the porters' dining room.

Mr. Goodrich suggested transferring the chairs from the former private pavilion dining room to the nurses' dining room and using some of the nurses' chairs for the porters' dining room.

Mr. Goodrich reported progress with the construction of the general storeroom. He also mentioned that latches on the elevator doors of the nurses' home had been broken and other damage done by employees, for the repair of which the offenders should be charged.

Mr. Goodrich further reported that, due to a plumbing stoppage in the east pavilion basement, work for the entire day in the physiotherapy department had to be suspended. Towels, sheets and gauze had been thrown into the hopper.

Mr. Goodman reported that recently a discharge slip for an employee had been made out two or three weeks after the employee had been discharged, resulting in a loss of about \$15.

Mr. Goodfriend mentioned that the walls of the stairway in the administration building between the second and third floors needed painting and also some of the rooms in the South pavilion. He also mentioned that the employees of the office, laboratory and occupational departments had, on several occasions, asked for a recreation room.

### WHAT CONSTITUTES A HISTORY?

Frequently essential data are found missing from the histories turned in after the discharge of the patient, with the result that considerable time and effort are expended in securing their completion in many hospitals. Occasionally a history is necessarily accepted and filed in an incomplete form.

An investigation made at one hospital revealed the fact that each intern had a different idea of what should be included in a history. Every intern failed to consider certain facts essential, and no two attendants had similar views regarding the extent or scope of the information required. With this difference of ideas proper completion was obviously impossible.

To the end that accurate information might be supplied to all interns, a complete list of the essential data was made up, printed, and distributed. This simple procedure resulted in the elimination of difficulty and in economy of time and labor.

The list adopted by this hospital follows:

All patients treated in the hospital must have a complete history that must include:

(1) History and diagnosis of admitting physician if patient is admitted through the hospital examining room; this to include results of any laboratory examination made in the hospital before admission to the ward or room.

(2) Histories by the intern or attending physician.

(3) Findings on physical examination by intern or attending physician.

(4) Tentative diagnosis.

(5) All laboratory reports.

(6) All x-ray reports.

(7) Operation record, if operated on.

(8) Anesthetic record, if anesthetized.

(9) Temperature charts.

(10) Notes on progress.

(11) Nurse's clinical record.

(12) All reports of examinations made by attending physicians in other departments who may have examined the patient.

(13) Diagnosis at the time of discharge of patient which should include all complications and a definite statement of the condition of the patient, whether cured, improved, or unimproved.

If improved, the degree of improvement as accurately as possible.

If impaired or incapacitated, the degree as nearly as possible, unless the history furnishes such adequate information.

Notations: In case of private patients, the attending physician may supply the necessary information for history and notes on physical examination, if he does not wish a history taken.

The diagnosis should be written into the history as soon as made by the attending physician.

All histories and notes of the first physical examinations must be completed within forty-eight hours after admission to the hospital.



# The MODERN HOSPITAL

The Modern Hospital Publishing Co.,  
Inc.

OTHO F. BALL, M.D., President  
22 East Ontario Street Chicago, Ill.

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## HOW SHALL WE GRADE OUR SCHOOLS OF NURSING?

ELSEWHERE in this issue appears an article by Miss Laura Logan, R.N., dean of the Illinois Training School for Nurses, Chicago, on the grading of schools of nursing. Attention of our readers has previously been called to the formation of a committee representative of nursing, medical, hospital, public health and educational interests to deal with this problem. It is quite generally recognized by those who have given thought to the matter that something more effective than is now being done ought to be undertaken for the improvement of nursing education. Present indications are that the activities of the above mentioned committee will keep the subject well in the foreground in nursing and hospital circles for the next two or three years and will provoke constructive thought in the consideration of its many phases.

Nursing education, like most other professional education, has had its beginning in apprentice training. Law and medicine, in which professions this was particularly the prevailing early type of schooling, have slowly modified their educational facilities and methods until they are now on a university basis. Nurse training is, for the most part, still of the apprentice type.

The most serious question with which this committee will have to deal is how nursing education methods can be so modified as to conserve all that is good in the prevailing system and add all that is lacking to make the period of training the most productive in fitting the nurse for her professional work. This question could have been more easily answered some years ago, when nursing service was more limited in scope and, if one may borrow a term from the medical vocabulary, when nurses were almost exclusively engaged in general practice. Now there is increasing specialization in the nursing field. There is real need for better facilities for training public health nurses, for teachers in schools of nursing and for those who may fill the many executive and administrative positions open to members of the nursing profession.

One is fairly safe in saying that the existing schools are more nearly adequate to train the nurse who is to serve the sick in our homes and hospitals than the nurses who will engage in these newer, specialized fields. Hence it is important that those who assume the responsibility for inaugurating changes intended to improve nursing education, the need for which improvement may be more intimately related to these newer phases of nursing work, keep in mind what is

perhaps the more fundamental province of the nurse—service with the physician in the care of the sick.

It is reasonable to believe that the development of nursing education away from the apprentice system will not go so far as has legal and medical education. It is a question whether there can be less actual practice training than we now have without serious loss. In fact we see in medical education an increasing insistence on the values of clinical teaching and hospital intern training. To be sure, the academic and theoretical part of the nurse training curriculum, the laboratory teaching and the like should be markedly improved. So indeed may the practice teaching, but the fundamental importance of the latter must never be lost sight of. The university school of nursing with its greater emphasis on the scientific and theoretical aspects of nursing education, essential though it may be to meet special needs, must never become the typical school.

It goes without saying that the relation of nursing education to hospital administration is the crux of the whole problem, presenting more difficulties and demanding more comprehensive and statesmanlike consideration than any other phase of the question. The machinery used for nurse training is built into the very structure of the hospital organization. It functions not only in an educational way but vitally in relation to the care of the sick by the hospital. In recent years it has been quite easy to censure hospitals for alleged exploitation of the pupil nurse to the end of obtaining inexpensive nursing service for their patients. Seemingly it has not been so easy to give hospitals credit for what they have done to foster nurse training. But regardless of what might be said on this subject, whatever plan is evolved must be a joint product of the best thinking and the absolute fair-mindedness of all who participate in its formulation. Not all can approach the matter of the standardization of nursing education and the grading of nursing schools without prejudice. There are fears, misgivings and misunderstandings that must be cleared away before those who must work together will be able to do so with greatest promise of success. Though the improvement in nursing education be the primary aim of the undertaking, the needs of safeguarding the care of the sick in our hospitals, of attracting a high type of young woman to nursing as a profession and of providing an adequate supply of nurses to meet the increasing demand are matters of lesser significance. Whatever methods are devised to meet the situation, they will be most likely to succeed if they propose a gradual approximation of a well considered program of

development, starting with what we have today, as a basis upon which to modify and build.

Any scheme for grading nursing schools will inevitably lead to a decrease in the number of such schools, even though, from time to time, new schools shall be established. Schools now exist which will unquestionably fall below any minimum standard that will be established. The question arises, naturally enough, as to what the hospitals affected will do to obtain nursing service if they have to give up their training schools.

#### ANALYZING THE PNEUMONIA SITUATION

**O**N PAGES 487-493 of this issue appears a very interesting and thought stimulating discussion as to the need for hospitalizing patients suffering with lobar pneumonia.

Dr. C. C. Pierce, a member of the Chicago Pneumonia Commission, summarizes the findings of this committee, and draws therefrom some conclusions that should be of a very practical value to every hospital superintendent and physician.

Too often do we find a total absence of facilities for the proper institutional care of patients suffering with croupous pneumonia. Indeed, it is rather unusual for the average hospital to have a separate, properly ventilated room, or ward, for the treatment of this disease. That the pneumonia patients do better in cold air has long since been proved. But the ward for these patients must also have adjacent thereto a warm room, or cubicle, in which the patient can be examined without chilling him.

That the dissemination of pneumonia by contact alone is not only possible, but not at all rare, has often been demonstrated. About eighty per cent of all cases of pneumonitis are caused by a Type I, II or III pneumococcus, and over sixty per cent by the first two types mentioned. While from fifteen to eighty per cent of healthy persons harbor pneumococci in their mouths or throats, yet it is not frequent to find there pathogenic organisms of the first two types.

As Dochez and Avery have shown, it is very common for persons who are in close contact with Type I and II cases of pneumonia to harbor these organisms in their mouth and throat secretions. Indeed, in but eight-tenths per cent of healthy persons, compared with 11 per cent of persons convalescent from pneumonia, were pathogenic pneumococci found by the above-mentioned observers. These facts appear plainly to point to the active infectiousness of pneumonia, and

strongly to indicate the wisdom of isolation of lobar pneumonia in the hospital. This physical separation of patients with pneumonia, from others not so infected, is of further importance when one considers the hospital patient's lowered resistance to infection as compared with healthy persons, generally. There is much conclusive evidence as to the need for further protective measures, insofar as contagion in the home or hospital ward is concerned, as the disease spreads through contact with objects that have been infected by a carrier.

Disease producing pneumococci are rather constantly found in the dust from the floors of rooms or wards where pneumonia is being treated, and much less frequently, if at all, in the dust from environs where this disease is not found. Scrupulous cleansing of floors, window ledges, and baseboard corners, during and after pneumonia, is but meeting a most evident preventive medicine indication. The wisdom of the sterilization of throat and nose discharges, vomitus, soiled linen, wash-cloths, etc., cannot be disputed. It is questionable whether the enforced wearing of gauze masks by nurses and doctors, when in intimate contact with the patient, is justified.

J. M. Anders, among others, refers to the fact that the death rate from pneumonia is higher in hospitals than in general practice. There are probably several factors that explain this rather startling statement. The use of the hospital bed as a last resort; the harm done in moving the patient, as well as the fact that in public hospitals, at least, many cases have that dread combination of alcohol and pneumonia, are all in a measure productive of this result. That the therapeutics and general management afforded hospital patients are in no way inferior, but, indeed, often-times superior to home facilities is unquestioned. The use of some of the modern curative procedures, such as the sun-lamp, certain more or less specific sera, and diathermy, are usually impossible in the home. Of the greatest importance is the superior nursing that the sick man of modest, or even meager, means can secure in the hospital. The patient's presence in the hospital also means the absence of the danger of home contagion, and which, after all, is of prime importance to the public welfare.

The enactment of laws, requiring the reporting of pneumonia as a contagious disease, the education of the public as to the danger and means of transmission, and the destruction of every pneumococcus as it leaves the body of the diseased, are steps that will go far toward lessening the incidence of this dread, seasonal disease that annually takes such a heavy toll.

## TALKING IT OVER

TO YOU who carry the Christmas spirit of service throughout the year, to you who have dedicated yourselves to the sick and injured, to you whose daily life exemplifies the precepts of Him in Whose honor Christmas is observed, we extend our congratulations on the privilege that is yours to be in this work which carries out His teachings. We extend our best wishes for your personal and continued happiness.

THE yuletide has a special significance to those whose lives are bound up in relieving pain, suffering and anxiety. It is a time when our thoughts naturally center even more than usual around the humanities. If we have during the year allowed our too frequently stimulated sympathies to become somewhat chilled to the human side of our work, if the struggle with budgets has driven from our faces the sunlight of kindness and warmhearted understanding, the period of "peace on earth, good will toward men" should be a time for the rebirth of a greater understanding of those whose welfare is committed to our hands. If we can transmit this feeling to our co-workers and associates, the year which is to come will be fraught with accomplishment which is really worth while. Each of us, that he may live, must daily give a little of his heart to those unfortunates in the pain and travail of sickness and, giving thus, we grow in gentleness and usefulness to our fellowman.

WHAT about the interns in your hospital? Are they getting out of their period of service nothing excepting a little technical education and manual training? Are they being given the real spirit of usefulness to the sick? Are they being taught the place of the hospital in the community? Have they been brought face to face with the public health responsibilities and opportunities of hospitals? Are they going out with the stamp of men who have a broader and a bigger function than the mere pursuit of a livelihood? These young men and women are at a formative stage of their career. Their minds are as wax to impressions. With relatively little effort they can be trained in a manner which will advance very materially their usefulness to the hospital field. Here is a golden opportunity.

IS THE American flag displayed on or in your institution? Without knowing it, hospitals play a very considerable role in Americanization. No other country in the world has such magnificent institutions for the care of the sick and nothing else so well exemplifies the spirit of the American people as its hospitals. The very presence of the flag seems to suffuse the air of Americanism into the hospital. It is a cheerful flag. Its rich colors and beautiful symbolism raise the heart. It is not enough that it be shown on national and state holidays, it should be displayed every day in the year. It makes better citizens and its presence in a hospital brings to the sick an all-prevailing sense of protection.

IN A recent magazine article the student-nurse-author states: "In my humble opinion short hair has done a great deal more than the eight-hour schedule to make our work bearable." The writer went on to explain that it saved time in the morning, and all of us, even those with student-nurse days far behind know how valuable time is at that crucial period of the day. This brought to the mind of one reader the question of uniforms. Many

of them are still being made with fitted basques and full, gathered skirts requiring many buttons and pins to keep them together. Then the aprons, with straps crossed in the back in a fashion that is guaranteed to make anyone look round-shouldered, require more buttons or pins. The collars, cuffs and caps usually necessitate a few more buttons, pins or studs! How much time (not only of student-nurses but of seamstresses and laundresses as well) might be saved if uniforms were more simply made, with less material, fewer buttons and easier to get into. If such a "sacred thing" as the uniform is to be changed couldn't it be made so that it would be complete and presentable without the apron, which should be worn only while the nurse is on duty, not off duty? And couldn't the apron be made in simpler fashion, so that the process of "putting on and off" would be simplified? After all, what are the essentials of a nurse's uniform? Has anyone ever worked them out?

\* \* \*

"**T**H E best citizen is the one who desires to improve his own town, not he who believes it better than any other." Paraphrase this and apply it to your own hospital. Would you qualify as a good citizen?

\* \* \*

**D**URANT Drake, professor of philosophy at Vassar, says that the question religious people must ask today is not "what shall I do to be saved" but "what shall I do to be of service?" Wouldn't it be a fine thing if we could bring all the people who believe this to the hospitals that are in need of workers? How can we make the connection?

\* \* \*

"**C**REATIVE energy in Europe six hundred years ago turned the world over. Delight in sheer beauty captured men, awakened force and nobleness in them, made them *be* themselves, made them so completely, so simply, so sincerely *be* themselves that their minds expanded wide as dreams. Great poetry, great paintings and great cathedrals came as a natural expression of their energy. Childlike happiness everywhere touched the common life. The color of the morning was on the clods."

Revealed here is a message full of optimism and inspiration for all of us, coming from that great sermonizer and leader, Chancellor John G. Bowman of the University of Pittsburgh, who uses these words under the caption "Carrying On," in a recent document discussing the larger work of the teaching institution of which he is the head. Hospitals, too, are teaching institutions and as such should heed the lesson herewith set forth. The ability to "be yourself" is an emancipation from error in a great many instances, and when fortified by logic and wisdom spells progress, without which the world would still be flat, hospitals would be pest houses and barbers, surgeons.

\* \* \*

**J**UST suppose that a fire should break out during the night in your hospital and you realized to your dismay that most of those patients that were unable to walk were housed in the part of the building made inaccessible by the flames. Of course, you know that this couldn't happen in your hospital because you are too good a superintendent but—think about it and talk it over with your board.

\* \* \*

**H**AVE you ever had the day suddenly glorified because someone recognized that you were making an effort to do good work and praised you for it? Hasn't it made

it easier for you to continue "trying" and hasn't it stimulated you to even greater effort?

Has this happened at your hospital or has your experience been the reverse? Probably because it is difficult to shake off military traditions this does not happen in our hospitals as frequently as it should. We are all prone to stimulate fear as a motive instead of many more positive and more effective motives. "The desire for approval," "to be thought well of" and "to have one's work commended" are all far more potent motives than fear, which brings with it a large measure of inhibition. Why not try them?

\* \* \*

**O**F PARTICULAR interest to all of us is the leading article of this issue by Dr. Goldwater who, had he not decided upon a hospital career might have become equally distinguished as a man of letters. His plea for a continuance of the present-day method of hospital support is especially applicable to the spirit of the season: "Under a purely public or state system the hospitals may be able to spend as much money as they do today, but the joy of spontaneous giving will be gone. . . . May American hospitals continue for generations to be 'supported by voluntary contributions'."

\* \* \*

**F**OR the purpose of teaching hospital personnel economy as well as educating them along other lines, this suggestion is offered by one of our readers:

"One of the many struggles in which hospitals are engaged is the constant one of trying 'to make ends meet.' This is not always appreciated by those who actually use supplies and one often hears the argument that gauze, cotton, etc., are cheap. If one thinks in small quantities this may be true, but the total cost of what the hospital uses each month is surprisingly high. Wouldn't it be wise to educate the hospital personnel in the cost of things? A beginning can be made by posting the actual cost of the requisitions that are filled for each unit, (ward, department, pavilion or whatever it may be) each month. In one instance this has stimulated economy in the use of supplies and has created a healthy rivalry between different wards as none of the supervisors wishes to be rated as extravagant."

\* \* \*

**D**O YOU ever slip quietly into the wards at night and stand there listening to the respirations of those occupying the long, quiet rows of beds? To your keen ear come the little rustlings of the bed clothes of those who are awake. The air breathes with their sighs and once in a while the semi-stillness is punctuated by a groan. In many of the beds the sick are lying with wide open eyes, looking at the dimly outlined ceiling. They seem to be waiting; they are watching for something; they are those that watch for the morning. To many of these the morning will bring a blessed relief from pain and anguish. To others it will bring new hope and added strength to go back into the battle of the outside world. To some it merely means a transfer from one trial to another since many must return to poverty, deprivation and disappointment. They that watch for the morning are looking to us of the hospital field to bring to them kindly, patient, understanding treatment. They want to be persons, not patients, and they want us to listen to them. We bring to them many mornings. Let us hope that all the mornings that we bring are filled with the warmth of kindly sunshine so that they that watch for the morning may not be disappointed.

## PREVENTING ILLNESS AND PROMOTING HEALTH AT MOOSEHEART

**I**N THE September issue of THE MODERN HOSPITAL Judge Elbert H. Gary is quoted as saying: "Every human being should go periodically to a hospital to be checked up. He ought to stay there a while, if possible, so that he can be observed for a reasonable length of time. We shall be a really progressive and educated people when doctors and hospitals are paid to keep us well rather than to feed us medicine and cut us up."

A concrete example of the logic of this statement is found at Mooseheart, Ill. "Mooseheart" is an institution created by the Loyal Order of Moose for the care and education of dependent children of deceased members of the order. At present the institution houses 1,250 children, ranging in age from twelve months to nineteen years. These children are fed, clothed, housed, educated and entertained at the expense of the fraternity.

Naturally such an institution is susceptible to epidemics of every kind. Children contract diseases more readily than adults, and they have not the reasoning power of their elders to insure the success of imposed quarantine or isolation. Yet in this extensive institution diphtheria and infantile paralysis are almost unknown. There has not been a case of diphtheria in Mooseheart for five years. This record is all the more remarkable when it is known that each month sees the entrance of a new group of children from diverse homes and environments.

It must be realized, however, that the Mooseheart hospital is a preventive rather than a restorative institution. When it is understood that the medical requirements of each of the 1,250 children are positively controlled, these and other astonishing health records are seen to be merely the result of Judge Gary's view put into actual practice.

### Minor Ailments Considered "Cases"

In Mooseheart the slightest abrasion of the skin, a small festering pimple, a bleeding nose, or any other minor ailment requiring the use of iodin or a bandage is considered a "case," just as is a tonsillectomy, a fractured femur, or whooping cough. Hence it is not surprising to learn that during the year 1924 there were over 30,000 "cases" in Mooseheart. It is little short of astonishing, however, that not one death occurred in the whole institution, and this in spite of the large number of serious cases confined in the ninety-bed hospital during the winter. This negative death rate is irrevocable evidence of the value of prevention and regular, periodic examination.

Every child entering Mooseheart is immediately subjected to a thorough physical examination. The findings

of this examination are entered on a 5x8" card which is carried in a permanent alphabetical file. With this card the attending physician can determine at a glance the findings of the first examination which includes: height, weight, chest, temperature, eyes, ears, nose, mouth, throat, teeth, tonsils, glands, lungs, heart, pulse, abdomen, genitals, nervous system, reflexes, skin, marks or deformities, and all impairments.

On the opposite side of this card is found the "Family History," which includes pertinent information regarding causes of death or medical attention to any member of

the child's immediate family; "tests," under which are given the dates of Schick tests, toxin and antitoxin, and vaccinations; "contagion"; "operations"; "x-ray"; and finally, the height and weight as taken every six months. There is also space for the recording of any remarks that may seem necessary.

Among the interesting policies adopted at Mooseheart is one that requires that every normal child drink at least one quart of milk daily. Any child that is found to be four or five pounds under weight is put in an open air cottage or dormitory, where special diets and more individual attentions are administered. Any youngster whose temperature rises one degree is immediately sent to the hospital. In the case of all minor hospital "cases,"

which include headaches, constipation, diarrhea, or similar illnesses, the child is given a hot bath, a weak laxative, a hot drink of some kind to produce a sweat, and is put to bed. Under this procedure the attending physician invariably finds when making his rounds the following day that the child is quite normal and ready for discharge before nightfall.

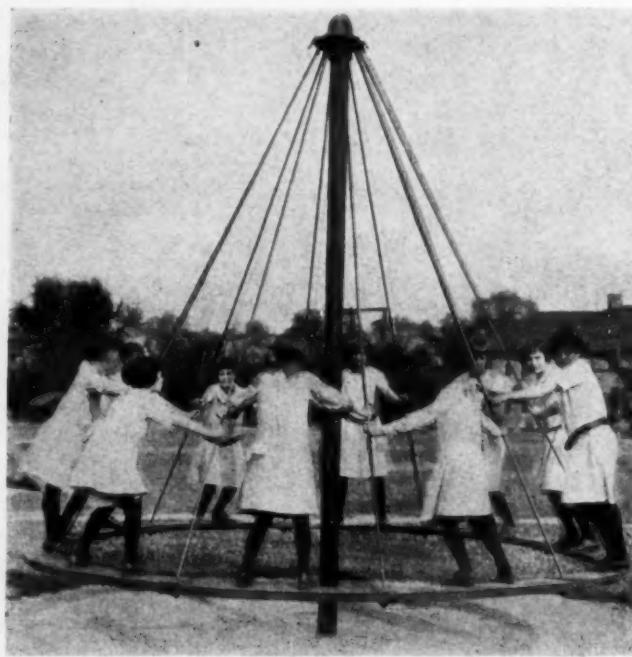
The attending physician's monthly report clearly reveals the amount of attention paid to the preventive side of medical practice. A report chosen at random brought forth the one for May, 1925. This report showed the number of children in the hospital to be 40, the number admitted during the month 237, the number discharged 253, and the number remaining in the hospital May 31, 24.

### Contagious Diseases Reduced to a Minimum

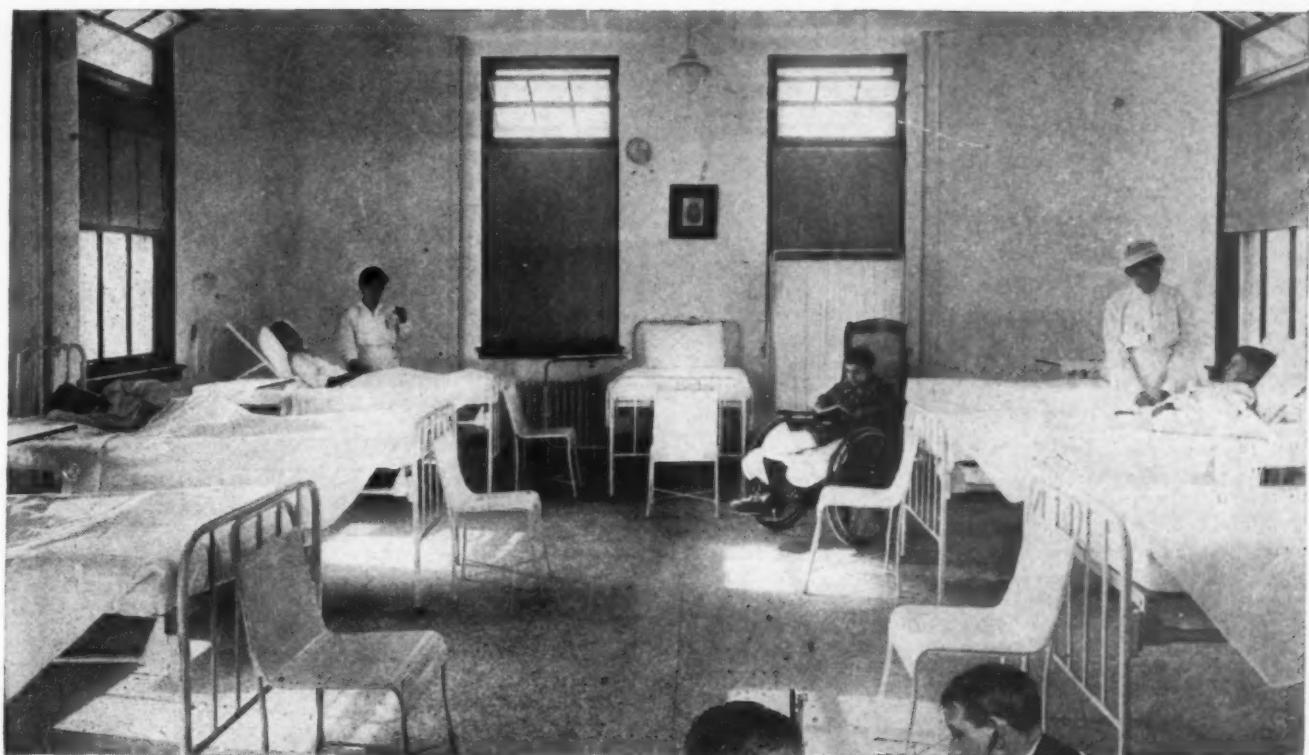
Under the classification of "Contagious Diseases" in this report were listed the following:

	May 1	New Cases	Discharged	May 31
Ringworm scalp .....	2	0	0	3
Measles .....	1	0	1	0
Chicken pox .....	0	6	5	1

Under the heading "Dispensary," however, there appeared 1,266 "consultations, treatments and visits"; 2,280 "school consultations and treatments"; 45 toxin-



Healthy outdoor games play an important part in keeping the Mooseheart children well.



*Above—A ward in the Mooseheart Hospital. Every child with a rise in temperature of one degree or with signs of even slight intestinal trouble is sent here for relaxation, rest and care.*

*Right—Dr. Nichols examining a boy who already appears a likely candidate for the National Guard. Upon entry, every child is given a Wassermann, a Schick, and a test for tuberculosis.*



antitoxin; 15 Von Pirquet, 1 Wassermann and 1 physical examination.

In contrast to this total of preventive measures there appear only 60 laboratory tests (of which 44 were urinalyses), 11 x-rays, 5 quartz light treatments, and 13 operations, all of which were minor.

#### Preventive Medicine in Actual Practice

"We shall be a really progressive and educated people when doctors and hospitals are paid to keep us well—" This is exactly what the physician and the hospital at Mooseheart are paid to do,—made possible because the administration can positively control its "hospital public." It is a matter of prevention rather than restoration, and the fact that not one death occurred during 1924,

among the 1,250 children proves the truth of the principle.

When we consider that the annual mortality rate for children in the United States is seventeen per thousand and that at Mooseheart there has been but one death per 1,250 children in the past three years it would seem that health centers of a similar nature would go a long way toward solving our problem of child health conservation.

There is no doubt but that if children could be afforded the same attention with respect to regularity in sleep, work and play and receive the close supervision and medical care that they are given at Mooseheart for the next century the dispensaries and hospitals of the country would be enabled to turn their full attention to preventive medicine.

## EFFECTING ECONOMIES BY MECHANICAL MEANS

By Sister M. Jane, Superior, St. Mary's Hospital,  
De Kalb, Ill.

**R**EALIZING that saving money on little things means increased service to patients, St. Mary's Hospital, De Kalb, Ill., has inaugurated several plans that have worked out satisfactorily. The hospital has a capacity of only sixty beds and has been in existence three years. While it has been the aim to save, it has not been the practice of stint, with the result that standards of quality have never been sacrificed.

One of the outstanding features that results in considerable economy is the laundry. Contrary to the practice in many small hospitals, particularly those located in small towns, St. Mary's does not send its soiled textiles to an outside commercial laundry. An exceptionally well equipped laundry is maintained and operated by the engineer and some of the maids.

One day each week is laundry day. The soiled linen, except that requiring immediate attention, is thus allowed to accumulate for six days. While this practice requires a larger supply of textiles than would otherwise be carried, it is believed that the investment in extra linen is justified. Because the accumulation never totals more than five or six tubfuls and since the work is done almost entirely by regularly employed help, the laundry is manned with little expense in addition to the items of interest, repairs and operating costs on the necessary equipment in operation.

In this small but efficient laundry is one eighty-four inch mangle of the return type, one steam press on the frame of which is mounted a stocking steamer, two electric irons, one large rotary tub, one tumbler, an extractor, a starcher and a boiler kettle for soft soap. The laundry room itself is well lighted and ventilated and spacious, and is ample for tables and drying racks.

### Laundry Work Well Apportioned

Each person assigned to laundry work has certain duties. For instance, the engineer operates all the laundry machinery with the exception of the mangle and the steam press. His work is the care of the tub, tumbler, extractor and soap kettle.

Maids from the house and kitchen operate the mangle, the electric irons, the press and the starcher. An extra woman, employed for the two laundry days of each week, does all the sorting, folding, assembling and distributing. Under this plan the hospital has only the expense of the machinery investment and the extra steam required on wash days, a total sum of about \$400 a year. The only wage chargeable to the laundry is that of the extra woman, an expense which when added to the operating costs gives a total approximating \$550 annually. This cost is contrasted with the \$2,400 annual laundry expense that would be incurred if an outside laundry did the work.

Another outstanding feature of St. Mary's is the kitchen. Unusual for small hospitals is the electric dishwasher which is one of the most appreciated of all time savers. With one operator this single tray machine does as much work in twenty minutes as would ordinarily be accomplished in one hour by three people.

The water for the dishwasher comes directly from the boiler room and is uniformly at boiling temperature. Such hot water, when allowed to play over the dishes continuously, effects a sterilization that would be quite

impossible with hand work in a much longer time.

In addition to saving the salary of one maid and doing the work better, the washer reduces breakage to a minimum. This reduction totals a large sum in the course of a year. Furthermore, there is no disposal of silverware with the garbage or dishwater, since with the electric washer there are no dishpans to empty. No dishpans means no dish rags, swabs, brushes or drying pans.

### Lifting Replaced by Piping

Over the large gas range in the kitchen are extended two three-quarter inch pipes leading directly from the hot water reserve tank to the boiler room. These hot water pipes are used to fill kettles, cooking utensils and all containers. This not only does away with the heavy lifting and carrying of containers from the sink to the stove, but provides hot water, thus reducing the amount of gas required to bring the water to the boiling point. The ends of these pipes are about twenty-four inches above the top of the stove so that they are no inconvenience to the maids.

When the hospital was opened, no electric toaster of sufficient size was available. Rather than employ the broiler for this purpose and consume large quantities of gas, a large flat, smooth-surfaced stone eighteen by thirty inches, similar to a soap stone, is laid over two of the burners. When heated, this stone serves exceptionally well as a bread toaster.

Connected with the kitchen is a large, well built refrigerator operated by a brine ice making machine which has been installed in the rear. Cooling the refrigerator with brine provides a uniform temperature of about thirty-six or thirty-eight degrees—a temperature fully ten degrees lower than would be possible if commercial ice were used.

In addition to providing refrigeration the machine, which is merely a five horse power motor, a carbonated gas tank and a two by four pump, can make 750 pounds of ice daily. This is more than is required by the hospital so that the machine is operated only four hours a day. The ice cakes are placed in the small refrigerators in each of the diet kitchens. Through the ice chambers of these small refrigerators is run a coil for drinking water, thus making ice water available at all times at no ice cost and without the possible contamination of the ice itself.

### Provision Against Emergencies

It may be of interest to note the several ways in which St. Mary's has provided against possible emergencies. In both major and minor operating rooms located on the third floor, there is an abundance of light afforded by the large windows and the overhead electric lamps, and gas lamps with illuminating power equal to the electricity are provided for emergency use. They have not been used as yet and will not unless the electricity fails just at the time surgical work is necessary.

Every room throughout the hospital, even to the telephone exchange room and the administrative offices, is equipped with sinks and lavatories and a small utility closet. This is merely emergency equipment for use in the event of unusual demand for hospital service that might force the utilization of every available space.

# A PROGRAM FOR THE GRADING OF SCHOOLS OF NURSING\*

Laura R. Logan, R.N., Dean, Illinois Training School for Nurses,  
Chicago

**G**RADING of Schools of Nursing. It sounds at first like a rather difficult, wearisome, discouraging, though essential piece of work; certainly one capable of precipitating many tribulations and presenting infinite problems. Doesn't it? We who are here tonight are all interested in it as it is likely to affect vitally the success and happiness of our individual hospital and school affairs.

Any such plan concerns us properly and challenges our critical attention. The grading of schools of nursing is a momentous and serious undertaking and could easily prove also a dangerous one to the best interests of all concerned. But it need not be dangerous to anyone who has as his ultimate desire to give all patients, at all times, the best nursing care, and to aid in the prevention of disease.

Indeed, the more one contemplates the possibilities and ramifications of a grading program for schools of nursing, the more one studies allied undertakings and the methods of one of them more particularly, the nearer one comes into the presence of a movement, of which the grading of schools of nursing may become an important part if we go about it rightly, which is the most stupendous, the most simple, the most sure and effective, and the most inspiring of any other single movement for human betterment in the complex social order of our day.

With the coming into existence of so many diverse and variously conducted programs of grading in other fields, high school, university, medical college, and hospital, it was natural that the idea of grading schools of nursing should present itself. In 1911 at the annual meeting of the National League of Nursing Education (which organization has always studied every means of advancing and improving nursing education) the idea of grading was first brought up for serious consideration, suggested by the grading of schools of medicine then in progress by the Carnegie Foundation. Indeed that foundation was approached for aid in financing such a plan, but it could not be secured.

## What "Grading" Means

As time has gone on there have been periods of clarity and periods of confusion as to just what might be done by grading of schools of nursing. We watched with considerable interest the method of classification applied to medical schools, dividing them into A, B and C grades, and we followed the minimum standard of the American College of Surgeons in the standardization of hospitals with even keener interest. One thing is evident that the mere term "grading" demands elucidation. It is not in itself explanatory either of the goal to be reached, the object in seeking it, or the relative merits of the different ways of carrying out any particular scheme or of being assured of its acceptance or the maintenance of standards after their establishment. Grading need not mean a static, arbitrary or unyielding pattern to be imitated. It can mean rather just a basic standard offered from which a school's progress may start on a course of

steady self-development. It need not mean coercion or criticism but rather a spirit of helpfulness. Indeed, the success of any plan chosen will depend upon the niceness of one's judgment as to the best means of getting it generally accepted and maintained.

A standard curriculum for schools of nursing was being outlined by the committee on education of the league. It was published in 1918 and made available to schools of nursing at cost, and through state leagues of nursing education and state boards of nurse examiners the schools were urged to study and introduce it. Its use has been very gratifying.

Study by a special committee of the league of the value and definition of a plan of grading was interrupted to await the report of the Study of Nursing Education by the Rockefeller Committee begun in 1919 and published in 1923. The Rockefeller Study carried out its object satisfactorily, "to survey the entire field occupied by the nurse, to form a conception of the tasks to be performed and the qualifications necessary for their execution and on the basis of such a study of function to establish minimum educational standards for each type of nursing service for which there appears to be a vital social need."

## Financing the Work

A tentative budget amounting to approximately \$115,000 for a three-year program was estimated by the league. The beginning of the work is made possible through the gift of \$10,000 from the three national nursing organizations themselves, and through the pledge of Mrs. Chester C. Bolton of Cleveland, to underwrite the plan for \$15,000 for its first year of work and to give further assistance if necessary. A number of alumnae associations also have pledged. As yet none of the great foundations approached have agreed to contribute to the plan.

The league's intention to formulate and put into action a scheme for grading or standardizing schools of nursing has been endorsed by the following organizations, and since a joint conference held March 4, 1925, a general committee on grading has been formed, constituted by delegates appointed by these organizations as follows: The National League of Nursing Education, two delegates: Elizabeth Burgess, R.N., and Laura R. Logan, R.N.; the American Nurses' Association, two delegates: Susan Frances, R.N., and Helen Wood, R.N.; the National Organization for Public Health Nursing, two delegates: Gertrude Hodgeman, R.N., and Katherine Tucker, R.N.; the American Medical Association, one delegate: William Darrach, M.D., and alternate Winford Smith, M.D.; the American Hospital Association, one delegate: S. S. Goldwater, M.D.; and alternate William H. Walsh, M.D.; the American College of Surgeons, one delegate: Malcolm T. MacEachern, M.D., and alternate Allen Craig, M.D.; the American Public Health Association, one delegate: C.-E. A. Winslow, M.D., and alternate Lee K. Frankel.

This committee has appointed in addition, four representatives from the field of university education and the public: Chancellor Samuel P. Capon of the University of Buffalo, Buffalo, N. Y., Dean Edward A. Fitzpatrick of the Graduate School of Marquette University, Milwaukee,

\*Read at American Hospital Association convention, Louisville, Ky., October 19-23, 1925.

Wis., President Henry Suzzalo of the University of Washington, Seattle, Wash., and Mrs. Chester C. Bolton of Cleveland. Pending the appointment of a permanent chairman, Isabel M. Stewart, Teachers' College, Columbia University, New York, chairman of the original league committee on grading, is acting as temporary chairman and secretary.

There has been as yet little opportunity for discussion by this committee of the policies and nature of the grading program. The grading committee has not definitely determined its plan of action nor what type of grading it will undertake. Shall we set out to create primarily a list of accredited schools that conform to some definite, more or less fixed standard, say that of the average good school of today? Let time bring what it will. That seems to me too static. Shall we set out to seek more uniformity and better standards among our schools of nursing? This is sought in all other educational groups; it would, therefore, seem desirable for us, too. Nor need we mean by such standardization only a uniform mediocrity but rather the formulation of a basic method of organization and equipment, the minimum without which it would not be safe to have a school of nursing at all. A basic method of organization and equipment from which a school can start on a course of steady self-improvement and which whenever established would beyond all peradventure involve that school in spontaneous and continuous growth from within.

#### Possible Plans for Grading

The question of grading nursing schools into three classes, A, B, C, as medical schools were graded was referred to as a possible plan in a partially attended preliminary meeting of our general committee. Such a procedure would afford a list of schools that would indicate to prospective students those which were excellent, good, and fair, or good, fair, and poor, depending upon how high a program of nursing education should be chosen as average. The value of such a list would depend upon how many schools were graded or could reach the grade. This brings the question of whether we should be welcomed by enough schools, as inspectors and graders, never a very welcome group in any institution, to make the list worth while.

Chancellor Capon stated, "I think the schemes for grading that have a number of grades that are all above the minimum is an exceedingly difficult scheme to administer and you never get satisfaction among the victims. It may be that dissatisfaction is worth securing in some instances. No doubt this is so, but I do not confess for myself that it is. I have never admitted that the American Medical Association didn't make a mistake in having three classes of schools above the condemnation. It would have been far better to have had one grade."

Dr. William J. Gies, who is engaged to classify dental schools under the Carnegie Foundation, and who spoke for the grading of dental schools said, "A classification into merely acceptable or non-acceptable would be more desirable than the A, B, and C method;" he called attention to the fact that "there is a more liberal attitude developing and criteria are now applied broadly and sympathetically rather than narrowly and arbitrarily."

As against the more arbitrary A, B, C type of grading stands the minimum hospital standard of the American College of Surgeons' program. When that organization came to the realization that they must shoulder the responsibility of furnishing a definite standard for hospitals, Dr. Franklin H. Martin states that the question arose as to whether it should specify the maximum or

minimum requirements. It was decided, after careful consideration, that the plan would be more workable and that "they could accomplish more by a minimum standard that would contain the fundamental requirements essential to every institution for the care of the sick, than by a maximum which would necessarily be burdened with unessential detail." He gives credit to Dr. John Bresnahan, a practical hospital expert on the staff of the college, for advice in this matter.

Dr. MacEachern and Dr. Craig, the representatives of the American College of Surgeons on our committee, are the men who are carrying out its program. They are convinced that it will be a mistake to begin any grading scheme of nursing schools in terms of A, B, C classification. They have found, after over 10,000 individual surveys of hospitals have been made, that the policy of a minimum standard is comparatively easy to put into action and has led to results far in excess of all expectations. It has stimulated universally a quickened desire on the part of a large percentage of hospitals in America and Canada to be not merely on the accredited list but to keep steadily improving, often far beyond any maximum standard that might fairly have been represented in a grade of A.

It is interesting to learn that the governments of Australia and New Zealand have asked Dr. MacEachern to visit these two countries during the year in order that their hospitals may be placed on a similar basis. I believe the method adopted by the college holds the greatest promise of success in our grading of schools and I do not believe it advisable to undertake an A, B, C classification.

The question of a job analysis, so called, was incidently raised during the preliminary conference on grading schools of nursing and has received considerable attention since then. Miss Stewart addressed a letter to members of the committee and a small miscellaneous group of individuals and personnel organizations, asking for an opinion regarding the necessity of making an analysis of nursing functions to aid in forming a grading program of schools. Nearly all felt an analysis of function was essential. It is, of course, evident that the satisfactory formulation of a grading scheme presupposes a thorough working knowledge of the functions of the group to be graded. But considerable confusion has arisen regarding the necessity of a special job analysis at this time because those addressed were so variously informed regarding the adequacy of such analyses already in existence, such as the Rockefeller report, the Lovitt report, the files of the league. Moreover, the character and experience of the members of the general committee on grading were unknown to them as well as the fact that its membership is already in possession of a mass of data as well as its own first-hand knowledge on the subject. A job analysis could hardly hope to add materially to the knowledge we now possess.

#### Too Many Details of Function

The trouble is that we already have too many details of function to summarize. Abraham Flexner says in his discussion of a curriculum for the medical student: "No two persons would ever agree on the particular set of facts and skills which the practitioner needs to master." Dr. MacEachern believes that no job analysis further than those that have already been made should be undertaken, and that little time should be lost or expense incurred in reaching a working analysis of nursing functions. I feel he is right. Besides we cannot hope to agree on particular skills, any more than could the medi-

cal group, and even if we could we must take care lest we fail to map out the woods for seeing only the trees.

The question of a lay director of the movement of grading or a lay person to conduct a possible job analysis has been placed before the committee. The representatives of the American College of Surgeons and Dr. Fitzpatrick, Dr. Walsh and myself wish to emphasize the position that the work should not be under a lay person but entirely under the direction of a very capable, highly trained nursing leader, who will bring to it the widest possible background of personal experience in the field of hospital administration and nursing education.

In studying other grading movements to arrive at some formulation of opinion in the matter of the nursing program, my mind and heart have been deeply stirred by the response the hospital world has made to the minimum standard program of the American College of Surgeons. The idea of reading the bulletins of the hospital standardization series of the American College of Surgeons, like the idea of giving attention to the grading of nursing schools, sounded prosaic and dull at first contemplation. Instead it proved a most unexpected experience. These bulletins quite move you. They have throughout a fine literary flavor and all the glow and thrill of a gospel. One cannot go far before one is convinced that they are the key to the successful issue of our grading program.

#### A. C. of S. Method Good Model

The method adopted by the college furnishes so good a model and points the way so clearly to a successful method of grading schools of nursing that I shall describe it somewhat carefully, and let the analogous plan for grading schools of nursing that I would indicate follow briefly at the end.

Dr. Harvey Cushing in describing the program of standardization shows how in the beginning it was purely selfish, that it grew out of the need of the American College of Surgeons to standardize the workshop (the hospital) of its candidates for fellowship. Soon they forgot themselves in the greater discovery that only by making the hospitals right in all respects could they attain their own ends. He adds, "their sincerity was soon recognized, their disinterestedness welcomed, and the fact that their program represented an ideal that made actual greater efficiency in hospitals attracted toward its support all people and all organizations interested in more efficient care of the sick."

In June 1924 Dr. MacEachern stated: "Our institutions have increased at least 50 per cent in efficiency during the last six or seven years since the college took up the cause of hospital betterment." A method that will produce such results sounds curiously like what the League of Nursing Education covets for schools of nursing and hospital departments of nursing.

We find the Rev. Charles B. Moulinier, president of the Catholic Hospital Association, speaking on standardization as early as January 1922, saying: "Some five or six years ago the American College of Surgeons, stirred to the depths of its soul, began to realize that it had a mission to fulfill for the better care of the sick in the United States and Canada and made up its mind to improve surgery. But everybody knows that you cannot improve surgery unless you improve everything that centers is the work of the hospital, and so the American College of Surgeons had not gone very far into its effort and purpose to improve surgery when it realized that it had to improve everything in medicine."

Thus began what Father Moulinier told them that day they were doing for the country in so thoughtful, really

scientific deeply conscious way that "there is no doubt of it, gentlemen, if I am at all safe in my conclusions in the reading of history, that there has never occurred a movement equal to it in the past history of our race—and it is sure to reach the rest of the world."

The executive secretary of the board of hospitals and homes of the Methodist Episcopal Church says they intend to see the program put into effect, that they find laymen and boards of trustees are so immensely pleased with the progress they make by its adoption that they consider the extra costs well justified. I would like to borrow a method for grading nursing schools that would make laymen and boards supporting hospitals feel that way about improvements in nursing education fundamental to the best care of the sick.

In 1918, 12 per cent of the hospitals of 100 beds and over were approved, of 692 visited. In 1921 86 per cent of the hospitals of 100 beds and over were approved, of 961 visited, and 69.3 per cent of all hospitals of fifty beds and over in the United States and Canada surveyed, 2360 in all, were approved, and the hospitals under the control of the United States Navy, Army and Public Health Service and the Veterans' Bureau have been surveyed on request.

What is the secret of the success of the program? It seems to go back by common agreement, first to the fact that the initiation of the movement came through a trained medical mind, as well as through the accumulation of ideas of those who had actual practice in hospital administration; that the men formulating and guiding the work of the minimum standard and carrying it into the field were men of outstanding ability and experience in the field of hospital administration; and, second, to the brevity, simplicity, and nature of the minimum standard formulated. It is one calculated to set in motion growth and improvement from within, tending toward the better care of the sick; it is not a classification scheme imposed from without.

The minimum standard consists of five brief, fundamental working principles and conditions of hospital organization, so essential that no hospital without them was a safe place for the practice of medicine or the care of the sick; it is a document that has achieved international fame. "Briefly," states Dr. Franklin H. Martin, director general of the American College of Surgeons, "the minimum standard with which it was believed every hospital should conform, provides the following:

- (1) An organized medical staff comprised of qualified physicians and surgeons.
- (2) A monthly meeting of staff members to review the professional work of the hospital.
- (3) A system of comprehensive case records.
- (4) An acceptable clinical laboratory.
- (5) Satisfactory evidence by the hospital authorities that the medical staff of its institution is comprised of legal practitioners of medicine who are opposed to the division of fees."

#### Sick Must Not Be Neglected

This does not seem too much to ask to safeguard the sick. I wish we could do the same for our hospital nursing departments and schools. A few briefly stated fundamental principles of school and nursing staff organizations, records, standards of equipment, acceptable hospital facilities, supervision and distribution of services, admission regulations, curriculum, and living conditions—neither does this seem too much to ask to safeguard the care of the sick.

I do not think we should go very far afield for a func-

tional analysis upon which to base such a program. I think we should review the facts of nursing education projected and now in operation and summarize their essential principles and contents. As experts in the field of nursing school and hospital affairs I think we should review our concepts of the duties of the nurse, their range, historical developments and general trend, and, on the basis of those for which we deem her most peculiarly fitted and obligated to perform, we should proceed to formulate as briefly as possible, a minimum standard constituting those fundamental working principles for school and nursing department organization without which a school of nursing could not be safely recognized as a school of nursing at all.

I covet for the League of Nursing Education and the general committee on grading of nursing schools that we too should be invited to the "christening" of American Hospitals, so many of which are being named "accredited."

Let us bring to the christening of schools of nursing and nursing departments gifts of equal value to those that wise fairy, the American College of Surgeons, has been bringing to her hospital christenings these seven years; who comes not like the uninvited ugly fairy to criticise and make public and odious comparisons of the children christened, but to bestow such goodly gifts of character, alike upon the prindlings who invite her, that in the light of knowledge each becomes zealous and honest and fearless in searching out his own faults and shortcomings, brave in their eradication, and wise and full of joy in his attainments.

#### What the Minimum Standard Has Done

A few guiding principles called a minimum standard whose bestowal is among the most priceless, fruitful and convincing treasures within the power of choice or gift. No wonder the "christenings" have gone from 12 per cent to 86 per cent in five short years. No wonder communities and trustees are becoming proud of their hospitals and more conscious of their own obligation to be at the christening also, to bestow sound business policies and all the equipment and support that such a child deserves. No wonder these children, even those whose heredity was pretty discouraging, are developing into strong members of society and prospering and serving as never before. No wonder better medical treatment and care are being assured to everyone, everywhere, rich and poor throughout the breadth of the land. No wonder one's heart and mind are stirred with the hope that the nursing school and department child shall not be left anywhere giftless, a misguided, weak, poor little Cinderella, but that she too may be fostered and loved and strengthened and encouraged to grow beautiful, intelligent, gracious, dependable and useful in her maturity, deserving to be welcomed not only among those who serve the world with humility and skill, joy and pride, but welcome also, and untrammeled, among the learned of the land.

May a fitting place be made for her in the educational systems of our day. And may the paths she wears through vocational fields lead as directly as her duties there will permit to those paths she will travel inside the gates of higher learning and life's experience to broader understanding and truer usefulness.

Can we, as nursing leaders, emulate the methods of the American College of Surgeons? They sought to make hospitals the best possible place for the physician to heal the patient, for the graduate and the undergraduate physician to acquire clinical skill and medical knowledge immediate and remote; they sought to assure to the sick good

care in illness and help in keeping well. We seek to make nursing schools and nursing departments in hospitals just such places for the student nurse in the opportunities and ways to acquire skill and knowledge in nursing.

I think we may win the same favor and success in our undertaking as they have in theirs; even gain as great momentum in a short number of years if we successfully adapt and imitate their policies, impose no critical inspections, or invidious comparisons. We must make our gifts of character, our minimum standards, those essential to the presence of a school of nursing in a hospital, at all as few as possible, simple and practical guiding principles, not detailed, stereotyped outlines of attainment. Let them be formulated by nursing leaders, not lay people, in terms of first-hand experience in the field of nursing education, and nursing school and hospital administrative practice.

Finally, let the direction of the work and the offer of this minimum standard to the hospital schools be in the hands of a group of nursing leaders experienced in the problems, ways, needs and prejudices of the hospital, medical, and nursing world. Let us not be impatient or demand premature growth. Let us remember, as one of the members of the college put it, that "time is an essential factor in any creation" and that "it remains as true today as when it was written that 'he that believes shall not make haste'."

Let us not throw a great searchlight of critical analysis over the schools of the land to seek out the good and the evil of their ways, but let us kindle in each of them lights that will welcome us. We can turn these lights high enough to make clear all essential faults, but low enough not to show harsh outlines too discouraging at first. And as those within bring things to order they will themselves turn the light up higher to see a little clearer, and finally higher still that the community, too, may see how much pleasanter and more effective a place the hospital is since schools of nursing are adequate too.

#### WILLIAMSPORT'S NEW HOSPITAL REALIZED IN FIVE-DAY CAMPAIGN

By Dr. Rush E. Castelaw, Superintendent, Williamsport Hospital,  
Williamsport, Pa.

Williamsport's greater hospital is to become a reality as the result of the intensive campaign conducted from October 19 to 23, inclusive, when three hundred workers crossed the goal of \$600,000 with \$30,000 to spare.

The executive committee raised \$418,200; the physicians of the city raised among themselves \$51,530; the ladies executive committee raised \$25,750; and the nurses \$7,000. Thirty teams canvassing the wards and precincts of the city raised \$128,875.91, making a grand total on October 23 of \$630,355.91 payable within eighteen months.

The unusual thing about the campaign was the speed with which the work was accomplished, the enthusiasm and the unanimity of purpose that motivated the entire city, thus making possible Williamsport's greatest civic success.

The new building will more than treble the private room capacity and will enable the hospital to convert private wards into public wards, thereby increasing the capacity of the latter nearly 50 per cent. It will make possible recognition of the Williamsport Hospital as an institution of the first rank, because it will be able fully to comply with the requirements of the State Welfare Department and of the American College of Surgeons.

## REAL VALUES OF MEDICAL SOCIAL WORK

By Edna G. Henry, Social Service Department, Robert W. Long Hospital,  
Indianapolis, Ind.

**T**HE chief, if not the only, concern of a medical social service department should be the patient. The worth of all of its activities, standards, procedures and efforts may be determined finally and absolutely by its success or failure with the individual patient.

A medical social service department differs from all other social agencies in two ways. It is always found within—if not as an integral part of—another institution, a medical institution; and, whatever else is wrong with its clients, they are ill. As the medical institution presumably exists for the good of the patient only, the purpose of the social service department is thus determined also. As the business of the social worker is “the study of character under adversity,” the task of the medical social worker is clearly the study of character under the adversity of illness.

This at once brings her to the first and most important aspect of her work, that of giving assistance to the physician in the care or cure of the individual patient. This includes both obedience to the physician's orders and the further offering of such expert social case work as might assist him in his purposes.

As social case work is that attention to the individual which tends to solve his problems and involves balanced attention to his estate, to his physical condition and to his mental and spiritual progress, merely the effort to cure or care for the patient may start many activities and may involve before the end, help from many sources. To the physician health may be all important. To the social worker, health is but a means to an end, the making of a whole man. Yet the medical social worker must begin her activity by attention to the physical need only, then discover what besides health is lacking in the man and, as far as possible, delegate all social problems not dependent on disease to others.

### First Department Organized In 1905

It is true that medical social work is new. The first department was organized in 1905 and it took ten years to create a dozen. The other 406 have come in the last ten years. Naturally the work lacks uniformity, standards and general agreement concerning organization, procedure, records or methods. Many deplore this lack. The fact is, however, through the deplored variations has the work been allowed adoption—could it adjust itself to all parts of the country, to all sizes of communities and to all sorts of institutions. Others criticize the medical social worker's failure to feel responsible for the hospital and to the community. But there is one thing that never changes, the patient. He may vary his nationality, his color, and his creed, but always his human problems and his diseases remain the same. Even if the worker sees her relation and her obligation to the hospital and to her community, she can rest assured that the best service she can render either is to aid each patient who comes to her.

Nor need she fret over standards, technique, records or methods. Let her only be sure that she is using those which help her to deliver the maximum good. Methods, of course, are necessary, but they should be flexible and not adopted bodily for Joplin, Mo., because they have proved good in Boston or Baltimore. Thought, not forms, is needed.

This means that the social worker must know, not only what the doctor knows of his patient, but also all that she can learn of the environment and the temperament of each patient. For all of their unchanging problems, no two are ever exactly alike.

Of three patients with tuberculosis, apparently equally ill, one will die, one will commit suicide, and one will improve and return to work. Of three unmarried mothers with the same physical condition, and the same stories, one will give up her child, one marry the child's father, and one will go to work to support her baby. Two alcoholics will end, one in a penitentiary and one in the Volunteers of America. A patient may be blind and a beggar, or blind and a poet.

What makes these differences? It is the social worker's business to know. She must remove, for the doctor, all social obstacles standing in the way of obedience to his orders and recognition of truth.

A social service patient should be recognized as a resource, an assistant, an asset, a student. Yet he is all these and more. The patient knows, better than anyone else, the invisible and remote causes of trouble and how, if he had the strength, time, money or mind, he could remove them. That department which can so regard its patients and educate them, will not only cure their ills but will develop assistance for others. This means that the social worker must be at once a democrat, a prophet and a genius.

It takes such a worker to meet a great doctor on his own ground and, in the next instant, the patient on his. It is she who will see that the mere wearing of a brace involves money, mechanical skill, and a problem in psychology. A meal and a bath for a tramp usually lead to transportation or care. In getting the doctor's orders carried out for a case of myocarditis, she may need money, a change of employment, or cooking lessons for a wife. Exophthalmic goitre may mean not only persuasion to have an operation, but a careful study of the dispositions of five devoted but misguided daughters.

When the tuberculosis patient has the fresh air, food, and regular medical attention, it may be the social worker alone who can secure the peace of mind equally essential. Nor does a brace end the care of a cripple or convalescence that of a cardiac child. In the restoration of physical or social health there is always education.

### HOSPITAL FACILITIES FOR PEOPLE OF MODERATE MEANS

“There is no question to my mind that the part-pay service contribution that is made by the private hospitals is the biggest piece of community service that any private hospital renders,” states Frank E. Chapman, director of Mount Sinai Hospital, Cleveland. “From an ideal point of view free patients should be taken care of by the municipal institutions, and facilities furnished in private hospitals at rates commensurate with the patient's ability to pay, to the end that the man of moderate means may be able to go to an efficient hospital.”

“The deficit produced by the assessing of charges within the ability of a patient to pay is a definite community contribution and as such should be compensated for by the community.”

## DEMONSTRATIONS AND ROUND TABLES FEATURE CHILDREN'S HOSPITAL MEETING



The group of children's hospitals executives who attended the conference at the James Whitcomb Riley Hospital for Children, October 24, 1925.

**F**Ifty or more representatives from children's hospitals and child-caring institutions throughout the country convened in Indianapolis on October in a one-day conference on administrative problems peculiar to children's hospitals.

The forenoon was given over to administrative considerations of child patient problems from such authorities as Dr. Ruth Wheeler, State University of Iowa Hospital, on dietetics; Dr. Howard Childs Carpenter, Children's Hospital of Philadelphia, on the children's hospital as a community center for health teaching; Dr. Isaac A. Abt, Northwestern University Medical School, on the prophylaxis of contagion in children's hospitals; and Miss Winifred Conrick, James Whitcomb Riley Hospital, on the requirements of occupational therapeutic departments.

Clinics open to all visitors were held in the afternoon on acute and sub-acute conditions in children's diseases, by Dr. Abt, whose lecture clinic constituted a comprehensive demonstration of what a child's physical examination should be, and by Dr. Vilray P. Blair, Washington University School of Medicine, St. Louis, on cleft palate work and plastic surgery of the face in general.

### Study Groups for Specialists

The meeting was a particularly happy example of the profit that accrues when study-observational opportunity is properly organized for the benefit of specific groups. The James Whitcomb Riley Hospital itself commanded much interest as an object lesson in organization and equipment for efficiency. The round-table discussion, during luncheon, on hospital affiliations, recreation, nursing, and other problems was too generally participated in to permit covering all of the topics announced, but the foundation was laid for a children's hospital forum for the elucidation of many moot questions encountered by this special group.

The conference resulted from a feeling on the part of the James Whitcomb Riley Hospital for Children that a much greater solidarity is desirable among children's hospital groups. Early in the deliberations of the meeting an organization committee was formed consisting of Dr. Howard Childs Carpenter, Philadelphia; Miss Marion S. Reynolds, Columbus, and Miss Estelle A. Claiborn, St. Louis. The committee's report during the luncheon meeting in favor of permanent organization resulted in the election of Robert E. Neff, Indianapolis, president, and

Miss Bena M. Henderson, Milwaukee, secretary-treasurer. An executive committee, to proceed at once toward framing the constitution and by laws was named by Mr. Neff. It consisted of the following: Dr. Isaac A. Abt, Chicago; Ida C. Smith, Boston; Florence J. Potts, Atlanta, and the president and secretary-treasurer ex-officio members.

It is the plan of the newly formed organization to work in close affiliation with the American Hospital Association. The next meeting is planned to take place in conjunction with the larger hospital group. The sessions will be arranged both in time schedules and scope to serve everyone who may be interested to attend, and definite plans are even now under way to collaborate with the pediatrics group of Philadelphia to present clinics and conferences of the utmost value to hospital executives in particular and to the cause of children's medical service in general.

### SEVEN EMPLOYEES RECEIVE AWARDS FOR THIRTY-FIVE YEARS' SERVICE

Recently, in the presence of a large gathering of the employees of Mount Sinai Hospital, New York, each of seven employees who had given faithful service to the hospital for thirty-five years or more was presented with a purse of one hundred dollars and a gold medal suitably designed and inscribed.

After an introductory greeting by Waldemar Kops, chairman of the board's committee on welfare of employees, Leo Arnstein, acting president of the hospital, expressed in generous terms the gratitude of the hospital for the service rendered, and emphasized the importance of loyalty to the hospital.

The gold medalists were Annie and Kate Fitzgerald, ward maids; Mary Hannan, Kate Keating, Kate Martin and Lizzie Walsh, laundresses; August Gessler, orderly.

The effect of color schemes on the minds of patients in sick rooms was appreciated long before the existence of organized hospitals. In the old records of the Hospital of the Knights of St. John, in London, founded during the first crusade, appeared the following order: "For alle those wymen in childebed, for those languishing in melancholic fevers and all those who are downcast by ye weight of theire afflyction, lette the chamber in which they are couched be of most lightlie coloured walls and tapestrie, to fare the sufferer merrilie and welle."

## PROBLEMS OF MEDICAL AND SURGICAL STAFFS DISCUSSED AT A. C. OF S. CONFERENCE

THE Hospital Standardization Conference of the American College of Surgeons held in Philadelphia, October 26-28, attracted the attention of not only the surgeons of this and other countries, but also of hospital administrators, as was proved by the large registration, totaling 2,500.

The Philadelphia Hospital Association had prepared for printing by the American College of Surgeons a directory of hospitals in Philadelphia, which was comprehensive and practical.

An excellent program had been prepared by Dr. Malcolm T. MacEachern, director, American College of Surgeons, hospital activities, Chicago, and clinics were given in most of the representative hospitals of Philadelphia during the week.

Of particular interest was the fact that so many distinguished foreign visitors were in attendance, and chief among them may be mentioned the names of the Right Honorable Lord Dawson of Penn, physician in ordinary to His Majesty, King George V, and Sir William Arbutnott Lane, of London, England.

On Wednesday, a luncheon was given by the staff of the Philadelphia General Hospital, at which Dr. Charles W. Mayo, Doctor Lane and Doctor Dawson were in attendance.

The scientific program, given in the ballroom of the Bellevue-Stratford, was of the highest grade of excellence. From the opening address by the president, on Monday morning, until the convocation of the college on Friday, many excellent papers were read. The discussions that followed these presentations were of the most interesting and instructive type.

Special prominence was given to the medical staff, of the hospital, insofar as it affected the hospital's efficiency, as well as to the relationship between the medical staff and the other staffs of the hospital. This appeared to be the outstanding feature of the program. Of course, the standardization of the hospital, with group monthly conferences, and the problem of postmortems were covered from several angles.

### Group Conferences On Specialties

Monday was given up to the presentation of stated papers. On Tuesday group conferences began with one on ophthalmology and oto-laryngology, conducted by Dr. James A. Babbitt, Philadelphia. Dr. S. MacCuen Smith, professor of otology, Jefferson Medical College, Nashville, Tenn., urged the establishment in general hospitals of ophthalmological and oto-laryngological departments.

The manner of planning this department was presented by Dr. Edward Jackson, Denver, Colo., and the standardization of equipment, supplies and procedures, by Dr. W. W. Pearson, Des Moines, Iowa.

The organization of the department was set forth by Drs. J. A. Stucky, Lexington, Ky., John A. Kolmer, Philadelphia, Frederick M. Law, New York, and James Gwathmey, New York, who discussed the question of the clinical laboratory, x-ray, and anesthesia requirements of this department. Dr. J. Ralston Wells, Philadelphia, also took part in this discussion.

On Tuesday afternoon the hospital conference was conducted by Dr. Joseph C. Doane, director, Philadelphia General Hospital, Philadelphia.

It was felt by Dr. Eldridge L. Eliason, Philadelphia,

who discussed the question of whether the hospital had the right to insist upon preoperative procedures being strictly carried out, that the hospital should choose its surgical staff carefully, and if the members of this staff did not use good judgment in protecting in every way the welfare of the patient, the remedy lay in replacing the offending individual with a more careful surgeon.

A number of speakers presented the query as to whether, in elective operations, it was ever necessary to waive the recorded urinalysis and chest examinations. The opinion of the majority was that rarely, if ever, should this be necessary.

### Economy In the Surgical Department

The question of economy in the surgical department, insofar as the surgeon is concerned, was another subject that brought forth considerable comment. As one speaker tersely put it, if a surgeon were required to buy his own catgut and gloves the hospital would effect a great saving. It was felt that the hospital administrator has the right to insist that the strictest economy consistent with the patient's welfare be exercised by those working in the hospital's surgical department.

Dr. John B. Carnett, Philadelphia, presented an excellent paper on the means of protecting the hospital and its surgeons against damage suits by patients and their relatives. He stressed the point that it was necessary to have a form so printed that the surgeon would be legally permitted to perform whatever extra surgical procedures he found necessary during the course of the operation, even though the permission did not specifically state the names of these procedures prior to beginning his work.

A topic, which brought out some rather spirited discussion, was presented by Dr. I. S. Ravdin, Philadelphia, and Mr. Louis C. Trimble, New York. This discussion concerned the place of the intern at operation, in the ward, and in regard to the chief surgeon's private cases. A number of speakers deplored the fact that the intern of today is often expected to be allowed to do major surgery during his few months' service in the surgical department. More than one speaker stated that the intern would learn much more by standing across the table from a skilled surgeon and watching his technique than by endeavoring to perform an operation for which he was not properly trained.

Dr. Frank C. Hammond, Philadelphia, introduced the subject as to the chief surgeon's responsibility in maintaining a high percentage of postmortems. Dr. Hammond put this responsibility squarely up to the chief surgeon and stated that very frequently a low postmortem percentage was due to his indifference, or sometimes even actual opposition to autopsies.

The chairman expressed his opinion that more often the attitude of the public toward autopsies was one which was due to lack of education, while the physician in charge must take a greater portion of the onus for lack of autopsies.

John M. Smith, director, Hahnemann Hospital, Philadelphia, discussed the question of extra charges, and the feasibility of including in a flat charge, for day or week services, the extra charges that so often are a source of trouble to the hospital superintendent. Mr. Smith stated that at the Hahnemann Hospital this sys-

tem was in successful practice, and that no more laboratory work was ordered under this system than where the extra-charge system was in practice.

Dr. Ernest L. Hunt Worcester, Mass., opposed the lump-sum system, and stated that it was unfair to the patient who needed very little laboratory work to pay for the laboratory work of another patient who required more.

The advantages of open and closed hospitals was discussed by Dr. W. W. Leake, superintendent, Charity Hospital of Louisiana, New Orleans, and John H. Olsen, superintendent, Lutheran Hospital of Manhattan, New York.

Dr. Alfred Stengel, Philadelphia, conducted a group conference on medical service on Wednesday morning, October 28, at which excellent papers were presented by Drs. David Riesman, Elmer Funk, E. B. Krumbhaar, George Morris Piersol, and O. H. Perry Pepper, all of Philadelphia, and Dr. Herman Spitz, Nashville, Tennessee. Dr. Joseph C. Doane presented a paper on the ideal physical requirements for the medical department, from the standpoint of the internist.

#### Opposed to More than One Appointment

Dr. David Riesman was particularly opposed to one physician's holding three or four hospital appointments. He stated that if a physician properly cared for a continuous service in one hospital (and that, in his opinion, was the best type of service) he would have no time properly to serve another institution. He strongly urged that the director of the medical department be a full time, salaried man and that he have no private practice, except, possibly, certain hours during the day or week for consultation.

Dr. Elmer Funk deplored the dissection of the medical clinic into many subdivisions, as he believes that this

division of the medical clinic distorts the vision of workers with respect to the necessity of referring cases from the general medical clinic to these specialties. He felt that lues, for example, should be thoroughly studied in the general medical clinic before being referred to the genito-urinary clinic. He stated that a strong effort should be made to maintain the cohesion of the general medical clinic, and that specialty clinics should be created only for a particularly good reason.

Perhaps the strongest point made by Doctor Funk, was that cases, when referred by the medical clinic to the specialty clinic, should be returned to the medical clinic, with a specialty recommendation, and that in the same degree with which this reference was enforced would be the efficiency of the general medical clinic and its subdivisions.

#### The Laboratory as a Source of Stimulus

Doctor Krumbhaar believed that the laboratory should be a source of much stimulus to the scientific work throughout the hospital; that the autopsies, performed in the laboratory, should be secured by the chiefs and not by the laboratory. The importance of the laboratory was stressed, but the speaker stated that it must not be made the "tail to wag the dog;" referring, of course, to the fact that some laboratories seem to dominate the situation, and that the hospital itself appears to be rather an annex to the laboratory, rather than the laboratory, an annex to the hospital.

The Wednesday afternoon session consisted of hospital conferences, conducted by Dr. John D. Spelman, superintendent, Touro Infirmary, New Orleans, at which many of the questions that were left unsettled in the previous sessions were brought up for discussion.

## A. C. OF S. "APPROVED LIST" FOR 1925

DURING the year the American College of Surgeons completed the eighth annual hospital standardization survey for Canada and the United States. This work comprised (1) the eighth survey of hospitals 100 beds and over; (2) the fourth survey of hospitals 50 to 100 beds; (3) the second survey of hospitals (a) 35 to 50 beds, (b) national homes for disabled volunteer soldiers; (4) the first survey of the United States Army, Navy, Public Health Service and Veterans' Bureau hospitals.

#### Foreign Hospitals Want Standardization

A number of institutions in foreign countries expressed a desire to be on the approved list. Satisfactory arrangements for survey of these institutions were made and the necessary data secured, and nine of them were included in the approved list as announced on October 26. A summary of the work completed is as follows:

Total number of hospitals surveyed.....	2,380
Number of hospitals fully approved.....	1,365
Number of hospitals conditionally approved.....	199
Total number of hospitals approved.....	1,564
Percentage of hospitals approved.....	65.7

A comparison of 1925 statistics with those of former years shows a gradual increase in the number of hospitals meeting the standard from year to year. During the past year the college directed its efforts particularly towards hospitals not on the approved list and those on the list conditionally approved. An earnest effort was made to bring every institution up to the minimum standard requirements. The response was most encouraging.

The survey for 1926 will be carried on to the same extent as in former years. So far as possible there will be a districting of the United States and Canada and the organization of a permanent staff of hospital visitors. Through this means the college will be able to keep a more continuous contact with each hospital throughout the year, and thus render an efficient background of service to the survey. A more intensive study of the hospital in its various physical phases will be made and particular attention directed to the characteristic spirit of the institution in relation to the principles of hospital standardization and the care of the patient. Efforts will also be made for the representatives of the college to attend as many staff conferences as possible with a view to assisting hospitals in carrying on this feature in the way as intended in the minimum standard. The hospital information and service department will be prepared to cope with the greater demand for service from the various hospitals covered in the survey, and every possible effort will be made to stimulate each institution to a greater service to the patient, the doctor, the nurse and the community.

The asterisk (\*) indicates conditional approval, or that the hospitals, while they have accepted the requirements and are putting them into effect, owing to lack of time or other acceptable reasons, they have not been able to carry them out in every detail. The final list of hospitals for the year 1925 will be published by the college, January 1, 1926.

# HOSPITALS OF 50 BEDS AND OVER MEETING A. C. OF S. MINIMUM STANDARD

	100 or more beds			50 to 100 beds			All hospitals over 50 beds		
	Number of hospitals	Approved		Number of hospitals	Approved		Number of hospitals	Approved	
		Number	Percentage		Number	Percentage		Number	Percentage
Alabama.....	10	10	100	19	6	31.5	29	16	55.1
Arizona.....	2	2	100	5	3	60	7	5	71.4
Arkansas.....	7	7	100	10	8	80	17	15	88.2
California.....	58	51	87.9	30	12	40	88	63	71.5
Colorado.....	12	12	100	9	5	55.5	21	17	80.9
Connecticut.....	18	18	100	9	6	66.6	27	24	88.8
Delaware.....	1	1	100	2	2	100	3	3	100
District of Columbia.....	11	11	100	1	0	..	12	11	91.6
Florida.....	7	4	57.3	8	3	37.5	15	7	49.9
Georgia.....	12	11	91.7	17	9	53	29	20	69
Idaho.....	1	1	100	8	6	75	9	7	77.7
Illinois.....	68	52	76.5	56	20	35.7	124	72	58
Indiana.....	26	19	73.1	17	10	58.8	43	29	67.4
Iowa.....	17	13	76.5	28	16	57.1	45	29	64.4
Kansas.....	7	7	100	28	18	64.2	35	25	71.4
Kentucky.....	9	9	100	16	10	62.5	25	19	76
Louisiana.....	9	9	100	10	8	80	19	17	89.5
Maine.....	6	5	83.3	9	4	44.4	15	9	60
Maryland.....	18	16	88.8	9	6	66.6	27	22	81.4
Massachusetts.....	51	47	92.1	33	21	63.3	84	68	80.9
Michigan.....	28	27	96.4	21	14	66.6	49	41	83.6
Minnesota.....	29	27	93.1	19	9	47.3	48	36	75
Mississippi.....	7	4	57.1	10	5	50	17	9	52.9
Missouri.....	31	28	90.3	19	11	57.8	50	39	78
Montana.....	8	7	87.5	10	6	60	18	13	72.2
Nebraska.....	12	8	66.6	10	5	50	22	13	59
Nevada.....	0	0	..	3	2	66.6	3	2	66.6
New Hampshire.....	1	1	100	14	9	64.2	15	10	66.6
New Jersey.....	36	36	100	15	11	73.3	51	47	92.1
New Mexico.....	0	0	..	5	4	80	5	4	80
New York.....	134	123	91.8	74	46	62.1	208	169	81.2
North Carolina.....	8	3	37.5	23	19	82.6	31	22	70.9
North Dakota.....	5	5	100	7	2	28.5	12	7	58.3
Ohio.....	45	44	97.8	38	9	23.6	83	53	63.8
Oklahoma.....	2	2	100	16	3	18.7	18	5	27.9
Oregon.....	5	5	100	17	7	41.1	22	12	54.5
Pennsylvania.....	93	89	95.7	71	49	69.1	16.4	13.8	84.1
Rhode Island.....	5	5	100	3	2	66.6	8	7	87.5
South Carolina.....	6	5	83.3	10	3	30	16	8	50
South Dakota.....	5	5	100	12	9	75	17	14	82.3
Tennessee.....	11	10	90.9	12	8	66.6	23	18	78.2
Texas.....	26	23	88.5	28	14	50	54	37	68.5
Utah.....	5	5	100	1	1	100	6	6	100
Vermont.....	2	2	100	6	4	66.6	8	6	75
Virginia.....	8	7	87.5	29	22	75.8	37	29	78.3
Washington.....	19	16	84.2	18	10	55.5	37	26	70.2
West Virginia.....	12	9	75	24	16	66.6	36	25	69.4
Wisconsin.....	26	24	92.3	27	11	40.7	53	35	66.2
Wyoming.....	2	1	50	4	3	75	6	4	66.6
Totals for United States	921	812	88.2	870	485	55.8	1791	1297	72.4
Alberta.....	7	7	100	4	4	100	11	11	100
British Columbia.....	8	8	100	7	1	14.4	15	9	60
Manitoba.....	9	9	100	3	0	..	12	9	75
New Brunswick.....	3	3	100	9	9	100	12	12	100
Nova Scotia.....	2	2	100	9	9	100	11	11	100
Ontario.....	30	25	83.3	26	12	46.1	56	37	66
Prince Edward Island....	0	0	..	3	3	100	3	3	100
Quebec.....	10	9	90	13	6	46.1	23	15	65
Saskatchewan.....	5	4	80	8	6	75	13	10	76.1
Totals for Canada....	74	67	90.5	82	50	69.8	156	117	75
Grand Totals.....	995	879	89.5	952	535	56.2	1947	1414	72.6

## UNITED STATES

## ALABAMA

100 or more beds  
 Birmingham Baptist Hospital, Birmingham  
 Employee Hospital, T.C.I.R.R. Co., Birmingham  
 Hillman Hospital, Birmingham  
 Mobile City Hospital, Mobile  
 Moody Hospital, Dothan  
 Norwood Hospital, Birmingham  
 Providence Infirmary, Mobile  
 \*St. Margaret's Hospital, Montgomery  
 St. Vincent's Hospital, Birmingham  
 South Highlands Infirmary, Birmingham  
 50 to 100 beds  
 \*Alabama Baptist Hospital, Selma  
 Children's Hospital, Birmingham  
 Frazier Hospital, Dothan  
 John A. Andrew Memorial Hospital, Tuskegee  
 Vaughan Memorial Hospital, Selma  
 Walker County Hospital, Jasper  
 35 to 50 beds  
 Drummond Frazier Hospital, Sylacauga  
 Sylacauga Infirmary, Sylacauga

## ARIZONA

100 or more beds  
 Arizona Deaconess Hospital, Phoenix  
 St. Joseph's Hospital, Phoenix  
 50 to 100 beds  
 \*Gila County Hospital, Globe  
 St. Mary's Hospital and Sanitarium Tucson  
 Tucson Hospital, Tucson  
 35 to 50 beds  
 Miami Inspiration Hospital, Miami

## ARKANSAS

100 or more beds  
 Little Rock General Hospital, Little Rock  
 Missouri Pacific Hospital, Little Rock  
 St. Bernard's Hospital, Jonesboro  
 St. Louis Southwestern R. R. Hospital, Texarkana  
 St. Vincent's Infirmary, Little Rock  
 \*Sparkle Memorial Hospital, Fort Smith  
 State Baptist Hospital, Little Rock  
 50 to 100 beds  
 Davis Baptist Hospital, Pine Bluff  
 Fayetteville City Hospital, Fayetteville  
 Leo N. Levi Memorial Hospital, Hot Springs  
 Michael Meager Memorial Hospital, Texarkana  
 \*St. Edward's Mercy Hospital, Fort Smith  
 \*St. John's Hospital, Fort Smith  
 Trinity Hospital, Little Rock  
 Warner Brown Hospital, El Dorado  
 35 to 50 beds  
 \*Helena Hospital, Helena

## CALIFORNIA

100 or more beds  
 Alameda County Hospital, San Leandro  
 Angelus Hospital Association, Los Angeles  
 California Lutheran Hospital, Los Angeles  
 Children's Hospital, Los Angeles  
 \*Fabio Hospital, Oakland  
 \*Franklin Hospital, San Francisco  
 French Hospital, San Francisco  
 General Hospital, Fresno  
 General Hospital, Santa Barbara  
 \*Glendale Sanitarium and Hospital, Glendale  
 Hahnemann Hospital, San Francisco  
 Hollywood Hospital, Hollywood  
 Hospital for Children, San Francisco  
 Hospital of the Good Samaritan, Los Angeles  
 Loma Linda Sanitarium and Hospital, Loma Linda  
 Long Beach Community Hospital, Long Beach  
 Los Angeles General Hospital, Los Angeles  
 Mary's Help Hospital, San Francisco  
 Mater Misericordia Hospital, Sacramento  
 Mercy Hospital, San Diego  
 Methodist Hospital, Los Angeles  
 Mt. Zion Hospital, San Francisco  
 O'Connor Sanitarium, San Jose  
 Orange County Hospital, Orange  
 \*Pacific Hospital, Los Angeles  
 Paradise Valley Hospital, National City  
 Pasadena Hospital, Pasadena  
 Providence Hospital, Oakland  
 Sacramento Hospital, Sacramento  
 \*St. Francis Hospital, San Francisco  
 St. Francis Hospital, Santa Barbara  
 St. Helen's Sanitarium, Sanitarium  
 St. Joseph's Hospital, San Francisco  
 \*St. Joseph's Hospital, Stockton  
 St. Luke's Hospital, San Francisco  
 St. Mary's Hospital, San Francisco  
 St. Vincent's Hospital, Los Angeles  
 Samuel Merritt Hospital, Oakland  
 \*San Bernardino County Hospital, San Bernardino  
 San Diego County Hospital, San Diego  
 San Francisco Hospital, San Francisco  
 \*San Jose Hospital, San Jose  
 Santa Barbara Cottage Hospital, Santa Barbara  
 Santa Clara County Hospital, San Jose  
 Santa Fe Coast Lines Hospital, Los Angeles  
 Seaside Hospital, Long Beach  
 Southern Pacific Hospital, San Francisco  
 Stanford University and Lane Hospitals, San Francisco  
 Sutter Hospital, Sacramento

## UNIVERSITY OF CALIFORNIA HOSPITAL, SAN FRANCISCO

White Memorial Hospital, Los Angeles  
 50 to 100 beds  
 Clara Barton Hospital, Los Angeles  
 \*Community Hospital, Belmont  
 Golden State Hospital, Los Angeles  
 Kaspare Cohn Hospital, Los Angeles  
 Mercy Hospital, Bakersfield  
 \*Mills Memorial Hospital, San Mateo  
 Orthopaedic Hospital, Los Angeles  
 Ramona and Sequoia Hospitals, San Bernardino  
 \*Ross General Hospital, Ross  
 Scripps Memorial Hospital, La Jolla  
 Shriners' Orthopedic Hospital, San Francisco  
 St. Mary's Long Beach Hospital, Long Beach  
 University Infirmary, Berkeley  
 Woodland Sanitarium, Woodland  
 35 to 50 beds  
 Baby's Hospital, Oakland

## COLORADO

100 or more beds  
 Beth-El Hospital, Colorado Springs  
 Boulder-Colorado Sanitarium, Boulder  
 Children's Hospital, Denver  
 Denver General Hospital, Denver  
 Glockner General Hospital, Colorado Springs  
 Merey Hospital, Denver  
 Minnequa Hospital, Pueblo  
 St. Anthony's Hospital, Denver  
 St. Francis Hospital, Colorado Springs  
 St. Joseph's Hospital, Denver  
 St. Luke's Hospital, Denver  
 St. Mary's Hospital, Pueblo  
 50 to 100 beds  
 Beth Israel Hospital, Denver  
 Community Hospital, Boulder  
 Denver and Rio Grande Western R. R. Hospital, Salida  
 \*Mt. St. Rafael Hospital, Trinidad  
 \*Red Cross Hospital, Salida  
 35 to 50 beds  
 Atchison, Topeka, and Santa Fe R. R. Hospital, La Junta

\*Park Avenue Hospital, Denver  
 Parkview Hospital, Pueblo

## CONNECTICUT

100 or more beds  
 Bridgeport Hospital, Bridgeport  
 Danbury Hospital, Danbury  
 Grace Hospital, New Haven  
 Greenwich Hospital, Greenwich  
 Hartford Hospital, Hartford  
 Hospital of St. Raphael, New Haven  
 Lawrence and Memorial Associated Hospitals, New London  
 Meriden Hospital, Meriden  
 Middlesex Hospital, Middleton  
 Mt. Sinai Hospital, Hartford  
 Municipal Hospital, Hartford  
 New Britain Hospital, New Britain  
 New Haven Hospital, New Haven  
 St. Francis Hospital, Hartford  
 St. Mary's Hospital, Waterbury  
 St. Vincent's Hospital, Bridgeport  
 Stamford Hospital, Stamford  
 Waterbury Hospital, Waterbury  
 50 to 100 beds  
 Charlotte Hungerford Hospital, Torrington

\*Home Memorial Hospital, New London  
 \*Litchfield County Hospital, Winsted  
 Manchester Memorial Hospital, South Manchester  
 Norwalk General Hospital, Norwalk  
 \*William W. Backus Infirmary, Norwich

## DELAWARE

100 or more beds  
 Delaware Hospital, Wilmington  
 50 to 100 beds  
 Homeopathic Hospital, Wilmington

\*Physicians and Surgeons Hospital, Wilmington

## DISTRICT OF COLUMBIA

100 or more beds  
 Central Dispensary and Emergency Hospital, Washington  
 Children's Hospital, Washington  
 Columbian Hospital for Women, Washington  
 Episcopal Eye, Ear, Nose and Throat Hospital, Washington  
 Freedman's Hospital, Washington  
 \*Gallinger Municipal Hospital, Washington  
 Garfield Memorial Hospital, Washington  
 George Washington University Hospital, Washington  
 Georgetown University Hospital, Washington  
 Providence Hospital, Washington  
 Washington Sanitarium, Washington

## FLORIDA

100 or more beds  
 Duval County Hospital, Jacksonville  
 Jackson Memorial Hospital, Miami  
 St. Luke's Hospital, Jacksonville  
 \*St. Vincent's Hospital, Jacksonville  
 50 to 100 beds  
 East Coast Hospital, St. Augustine  
 Faith Hospital, St. Petersburg  
 Gordon Keller Memorial Hospital, Tampa  
 35 to 50 beds  
 Bayside Hospital, Tampa  
 Riverside Hospital, Jacksonville

## GEORGIA

100 or more beds  
 \*City Hospital, Columbus  
 Davis-Fischer Hospital, Atlanta  
 Georgia Baptist Hospital, Atlanta  
 Grady Memorial Hospital, Atlanta  
 John D. Archibald Memorial Hospital, Thomasville

\*Macon Hospital, Macon

Piedmont Sanitarium, Atlanta

\*Rawlings Sanitarium, Sandersville

St. Joseph's Infirmary, Atlanta

University Hospital, Augusta

Wesley Memorial Hospital, Atlanta

50 to 100 beds

Athenic General Hospital, Athens

Atlantic Coast Lines Hospital, Waycross

Downey Hospital, Gainesville

Harbin Hospital, Rome

\*Middle Georgia Sanitorium, Macon

\*St. Mary's Hospital, Athens

Scottish Rite Hospital, Decatur

Wilhendorf Hospital, Augusta

Wise Sanitarium, Plains

\*Phoebe Putney Memorial Hospital, New Albany

## IDAHO

100 or more beds

St. Alphonsus Hospital, Boise

50 to 100 beds

Latter-day Saints Hospital, Idaho Falls

Pocatello General Hospital, Pocatello

\*Providence Hospital, Wallace

St. Anthony's Hospital, Pocatello

St. Joseph's Hospital, Lewiston

St. Luke's Hospital, Boise

35 to 50 beds

\*St. Maries Hospital, St. Maries

## ILLINOIS

100 or more beds

Augustana Hospital, Chicago

Blessing Hospital, Quincy

Chicago Lying-in Hospital, Chicago

Chicago Memorial Hospital, Chicago

Children's Memorial Hospital, Chicago

Columbus Hospital, Chicago

Cook County Hospital, Chicago

Decatur and Macon County Hospital, Decatur

Evanston Hospital, Evanston

Frances E. Willard Hospital, Chicago

Garfield Park Hospital, Chicago

Grant Hospital, Chicago

Henrotin Hospital, Chicago

\*Hinsdale Sanitarium, Hinsdale

Hospital of St. Anthony de Padua, Chicago

Illinois Central Hospital, Chicago

Illinois Eye and Ear Infirmary, Chicago

John B. Murphy Hospital, Chicago

Lake View Hospital, Danville

Lutheran Deaconess Hospital, Chicago

Lutheran Memorial Hospital, Chicago

Mercy Hospital, Chicago

Michael Reese Hospital, Chicago

Misericordia Hospital, Chicago

\*Moline Public Hospital, Moline

Mt. Sinai Hospital, Chicago

Oak Park Hospital, Oak Park

Presbyterian Hospital, Chicago

Ravenswood Hospital, Chicago

Rockford Hospital, Rockford

Roseland Community Hospital, Chicago

St. Anne's Hospital, Chicago

St. Anthony's Hospital, Rock Island

St. Bernard's Hospital, Chicago

St. Elizabeth's Hospital, Chicago

\*St. Elizabeth's Hospital, Danville

St. Francis Hospital, Blue Island

St. Francis Hospital, Evanston

St. Francis Hospital, Peoria

St. Joseph's Hospital, Chicago

St. Joseph's Hospital, Joliet

St. Luke's Hospital, Chicago

St. Mary's Hospital, Cairo

St. Mary's Hospital, East St. Louis

St. Mary's Hospital, Kankakee

St. Mary's Hospital, Quincy

St. Mary of Nazareth Hospital, Chicago

Silver Cross Hospital, Joliet

South Shore Hospital, Chicago

Swedish Covenant Hospital, Chicago

University Hospital, Chicago

Wesley Memorial Hospital, Chicago

50 to 100 beds

Highland Park Hospital, Highland Park

Huber Memorial Hospital, Pana

Illinois Masonic Hospital, Chicago

Ingalls Memorial Hospital, Harvey

Kewanee Public Hospital, Kewanee

Lake View Hospital, Chicago

\*Lutheran Hospital, Moline

North Chicago Hospital, Chicago

Olney Sanitarium, Olney

Our Savior's Hospital, Jacksonville

Passavant Memorial Hospital, Jacksonville

\*Post-Graduate Hospital, Chicago

\*Provident Hospital, Chicago

St. Andrew's Hospital, Murphysboro

\*St. Elizabeth's Hospital, Granite City

\*St. Francis Hospital, Freeport

St. Francis Hospital, Kewanee

St. Joseph's Hospital, Alton

Washington Boulevard Hospital, Chicago

\*Women's and Children's Hospital, Chicago

- 35 to 50 beds*
- \*Berwyn Medical Unit, Berwyn
  - \*Streeter Hospital, Chicago
- INDIANA**
- 100 or more beds*
- Epworth Hospital, South Bend
  - Fort Wayne Lutheran Hospital, Fort Wayne
  - Gary Hospital, Gary
  - Indianapolis City Hospital, Indianapolis
  - \*Methodist Episcopal Hospital, Indianapolis
  - Methodist Hospital, Gary
  - \*Protestant Deaconess Hospital, Evansville
  - St. Anthony's Hospital, Terre Haute
  - St. Edward's Hospital, New Albany
  - St. Elizabeth's Hospital, LaFayette
  - St. Joseph's Hospital, Ft. Wayne
  - St. Joseph's Hospital, Mishawaka
  - St. Joseph's Hospital, South Bend
  - St. Margaret's Hospital, Hammond
  - \*St. Mary's Hospital, Evansville
  - St. Mary's Mercy Hospital, Gary
  - \*St. Vincent's Hospital, Indianapolis
  - Union Hospital, Terre Haute
  - University Hospital, Indianapolis
- 50 to 100 beds*
- Clinton County Hospital, Frankfort
  - Grant County Hospital, Marion
  - Holy Family Hospital, LaPorte
  - LaFayette Home Hospital, LaFayette
  - Muncie Home Hospital, Muncie
  - Reid Memorial Hospital, Richmond
  - St. John's Hospital, Anderson
  - \*St. Joseph's Hospital, Logansport
  - Wabash Valley Sanitarium and Hospital, LaFayette
  - Walker Hospital, Evansville
- IOWA**
- 100 or more beds*
- Finley Hospital, Dubuque
  - Iowa Lutheran Hospital, Des Moines
  - Iowa Methodist Hospital, Des Moines
  - Jennie Edmundson Hospital, Council Bluffs
  - Mercy Hospital, Cedar Rapids
  - Mercy Hospital, Council Bluffs
  - Mercy Hospital, Davenport
  - Mercy Hospital, Des Moines
  - \*Mercy Hospital, Iowa City
  - St. Joseph's Hospital, Dubuque
  - St. Joseph's Mercy Hospital, Sioux City
  - St. Vincent's Hospital, Sioux City
  - University Hospital, Iowa City
- 50 to 100 beds*
- Des Moines City Hospital, Des Moines
  - Iowa Congregational Hospital, Des Moines
  - Iowa State College Hospital, Ames
  - Jane Lamb Memorial Hospital, Clinton
  - Lutheran Hospital, Sioux City
  - Methodist Hospital, Sioux City
  - \*Ottumwa Hospital, Ottumwa
  - Park Hospital, Mason City
  - St. Francis Hospital, Waterloo
  - \*St. Joseph's Hospital, Keokuk
  - \*St. Joseph's Hospital, Keokuk
  - St. Joseph's Mercy Hospital, Clinton
  - St. Joseph's Mercy Hospital, Fort Dodge
  - St. Joseph's Mercy Hospital, Mason City
  - St. Joseph's Mercy Hospital, Waverly
  - St. Luke's Hospital, Cedar Rapids
  - \*St. Luke's Hospital, Davenport
- 35 to 50 beds*
- \*Atchison, Topeka, and Santa Fe R. R. Hospital, Fort Madison
  - \*Cedar Valley Hospital, Charles City
- KANSAS**
- 100 or more beds*
- Bell Memorial Hospital, Kansas City
  - Bethany Methodist Hospital, Kansas City
  - St. Francis Hospital, Wichita
  - St. Margaret's Hospital, Kansas City
  - Santa Fe Hospital, Topeka
  - Wesley Hospital, Wichita
  - Wichita Hospital, Wichita
- 50 to 100 beds*
- Axtell Hospital, Newton
  - Bethel Deaconess Hospital, Newton
  - Christ Hospital, Topeka
  - Grace Hospital, Hutchinson
  - Halstead Hospital, Halstead
  - Jane C. Stormont Hospital, Topeka
  - \*Mercy Hospital, Fort Scott
  - \*Missouri, Kansas and Texas R. R. Hospital, Parsons
  - Mount Carmel Hospital, Pittsburgh
  - Providence Hospital, Kansas City
  - St. Anthony's Hospital Hays
  - St. Anthony's Murdock Memorial Hospital, Sabetha
  - St. Elizabeth's Hospital, Hutchinson
  - St. Francis Hospital, Topeka
  - \*St. John's Hospital, Leavenworth
  - St. John's Hospital, Salina
  - St. Joseph's Hospital, Concordia
  - St. Rose's Hospital, Great Bend
- 35 to 50 beds*
- Hatcher Hospital, Wellington
- KENTUCKY**
- 100 or more beds*
- Baptist Hospital, Louisville
  - Good Samaritan Hospital, Lexington
  - Louisville City Hospital, Louisville
  - Norton Memorial Hospital, Louisville
  - St. Anthony's Hospital, Louisville
  - St. Elizabeth's Hospital, Covington
  - St. Joseph's Hospital, Lexington
- 35 to 50 beds*
- St. Joseph's Infirmary, Louisville
  - Sts. Elizabeth and Mary Hospital, Louisville
- 50 to 100 beds*
- \*Ashland General Hospital, Ashland
  - \*Booth Memorial Hospital, Covington
  - Children's Free Hospital, Louisville
  - \*Jewish Hospital, Louisville
  - Illinois Central Hospital, Paducah
  - \*King's Daughter's Hospital, Ashland
  - Lynch Mine Hospital, Lynch Mines
  - Methodist Episcopal Hospital, Louisville
  - Spears Memorial Hospital, Dayton
  - Wm. Mason Memorial Hospital, Murray
  - Robinson Hospital, Berea
- LOUISIANA**
- 100 or more beds*
- Charity Hospital, New Orleans
  - Charity Hospital, Shreveport
  - Hotel Dieu, New Orleans
  - North Louisiana Sanitarium, Shreveport
  - Our Lady of the Lake Sanitarium, Baton Rouge
  - Presbyterian Hospital, New Orleans
  - St. Francis Sanitarium, Monroe
  - T. E. Schumpert Memorial Hospital, Shreveport
  - Touro Infirmary, New Orleans
- 50 to 100 beds*
- \*Baptist Hospital, Alexandria
  - \*Elizabeth Sullivan Memorial Hospital, Bogalusa
  - Eye, Ear, Nose, and Throat Hospital, New Orleans
  - Flint-Goodridge Hospital, New Orleans
  - Highland Sanitarium, Shreveport
  - Illinois Central R. R. Hospital, New Orleans
  - Mercy Hospital, New Orleans
  - St. Patrick's Sanitarium, Lake Charles
  - Shriner's Hospital for Crippled Children, Shreveport
- 35 to 50 beds*
- \*New Orleans Dispensary for Women and Children, New Orleans
- MAINE**
- 100 or more beds*
- Central Maine General Hospital, Lewiston
  - Eastern Maine General Hospital, Bangor
  - Maine Eye and Ear Infirmary, Portland
  - Maine General Hospital, Portland
  - St. Mary's General Hospital, Lewiston
- 50 to 100 beds*
- Bath City Hospital, Bath
  - Children's Hospital, Portland
  - St. Barnabas Hospital, Portland
  - State Street Hospital, Portland
- MARYLAND**
- 100 or more beds*
- Allegany Hospital, Cumberland
  - Baltimore City Hospital, Baltimore
  - Children's Hospital, Baltimore
  - Church Home and Infirmary, Baltimore
  - Colonial Hospital, Baltimore
  - Franklin Square Hospital, Baltimore
  - Hebrew Hospital and Asylum, Baltimore
  - Hospital for Women of Maryland, Baltimore
  - Johns Hopkins Hospital, Baltimore
  - Maryland General Hospital, Baltimore
  - Mercy Hospital, Baltimore
  - \*Peninsula General Hospital, Salisbury
  - St. Agnes Hospital, Baltimore
  - St. Joseph's Hospital, Baltimore
  - Union Memorial Hospital, Baltimore
  - University Hospital, Baltimore
- 50 to 100 beds*
- Cambridge-Maryland Hospital, Cambridge
  - Emergency Hospital, Easton
  - Frederick City Hospital, Frederick
  - James Lawrence Kerman Hospital, Baltimore
  - South Baltimore Hospital, Baltimore
  - Western Maryland Hospital, Cumberland
- 35 to 50 beds*
- Howard A. Kelly Hospital, Baltimore
  - Volunteers of America Hospital, Baltimore
- MASSACHUSETTS**
- 100 or more beds*
- Beverly Hospital, Beverly
  - Boston City Hospital, Boston
  - Boston Lying-in Hospital, Boston
  - Brockton Hospital, Brockton
  - Burbank Hospital, Fitchburg
  - Cambridge City Hospital, Cambridge
  - Cambridge Hospital, Cambridge
  - Carney Hospital, Boston
  - Children's and Infants' Hospitals, Boston
  - City Hospital, Fall River
  - Cooley-Dickinson Hospital, Northampton
  - Free Hospital for Women, Boston
  - Gale Hospital, Haverhill
  - Henry Heywood Memorial Hospital, Gardner
  - Holyoke City Hospital, Holyoke
  - House of Mercy Hospital, Pittsfield
  - Lawrence General Hospital, Lawrence
  - Long Island Hospital, Boston
  - Lowell Corporation Hospital, Lowell
  - Lowell General Hospital, Lowell
  - Lynn Hospital, Lynn
  - Malden Hospital, Malden
  - Massachusetts Charitable Eye and Ear Hospital, Boston
  - Massachusetts General Hospital, Boston
  - Massachusetts Homeopathic Hospital, Boston
  - Memorial Hospital, Worcester
  - Mercy Hospital, Springfield
  - New England Baptist Hospital, Boston
- 35 to 50 beds*
- \*Abbott Hospital, Minneapolis
  - Ancker Hospital, St. Paul
  - Asbury Hospital, Minneapolis
  - Bethesda Hospital, St. Paul
  - Charles T. Miller Hospital, St. Paul
  - Colonial Hospital, Rochester
  - Deaconess Hospital, Minneapolis
  - Eitel Hospital, Minneapolis
  - Fairview Hospital, Minneapolis
  - Gillette State Hospital for Indigent Children, St. Paul
  - Kahler Hospital, Rochester
  - Maternity Hospital, Minneapolis
  - Minneapolis General Hospital, Minneapolis
  - Mounds Park Sanitarium, St. Paul
  - Northern Pacific Beneficial Association Hospital, St. Paul
  - Northwestern Hospital, Minneapolis
- MINNESOTA**
- 100 or more beds*
- \*Ishpeming Hospital, Ishpeming
  - Michigan Mutual Hospital, Detroit

St. Barnabas Hospital, Minneapolis  
 St. John's Hospital, St. Paul  
 St. Joseph's Hospital, St. Paul  
 St. Luke's Hospital, Duluth  
 St. Luke's Hospital, St. Paul  
 St. Mary's Hospital, Duluth  
 St. Mary's Hospital, Minneapolis  
 St. Mary's Hospital, Rochester  
 St. Paul Hospital, St. Paul  
 Swedish Hospital, Minneapolis  
 University of Minnesota Hospital, Minneapolis  
 Winona General Hospital, Winona  
 Worrell Hospital, Rochester  
 50 to 100 beds  
 Hill Crest Surgical Hospital, Minneapolis  
 \*Immanuel Hospital, Mankato  
 St. Gabriel's Hospital, Little Falls  
 St. Joseph's Hospital, Brainerd  
 St. Joseph's Hospital, Mankato  
 St. Luke's Hospital, Fergus Falls  
 St. Raphael's Hospital, St. Cloud  
 Shriner's Hospital for Crippled Children, Minneapolis  
 Warren General Hospital, Warren  
 55 to 50 beds  
 Morgan Park Hospital, Duluth  
 \*St. Andrew's Hospital, Minneapolis  
 MISSISSIPPI  
 100 or more beds  
 King's Daughter's Hospital, Gulfport  
 Matty Herse Hospital, Meridian  
 Mississippi Baptist Hospital, Jackson  
 Mississippi State Charity Hospital, Jackson  
 South Mississippi Charity Hospital, Laurel  
 50 to 100 beds  
 Houston Hospital, Houston  
 Jackson Infirmary, Jackson  
 Kings Daughter's Hospital (white), Greenville  
 South Mississippi General Hospital, Hattiesburg  
 Vicksburg Infirmary, Vicksburg  
 55 to 50 beds  
 \*Biloxi Hospital, Biloxi  
 Dr. Hairston's Hospital, Meridian  
 J. Z. George Memorial Hospital, A. and M. College  
 Tupelo Hospital, Tupelo  
 Winona Infirmary, Winona  
 MISSOURI  
 100 or more beds  
 Alexian Brothers Hospital, St. Louis  
 Barnes Hospital, St. Louis  
 Bethesda Hospital, St. Louis  
 Children's Hospital, Kansas City  
 Christian Church Hospital, Kansas City  
 Evangelical Deaconess Home and Hospital, St. Louis  
 \*Grace Hospital, Kansas City  
 Frisco Employees' Hospital, St. Louis  
 Jewish Hospital, St. Louis  
 Kansas City General Hospital, Kansas City  
 Kansas City General Hospital, Kansas City (Colored Division)  
 Lutheran Hospital, St. Louis  
 Methodist Hospital, St. Joseph  
 Missouri Baptist Sanitarium, St. Louis  
 Missouri Pacific R. R. Hospital, St. Louis  
 Research Hospital, Kansas City  
 St. Anthony's Hospital, St. Louis  
 St. John's Hospital, St. Louis  
 St. Joseph's Hospital, St. Louis  
 St. Louis Children's Hospital, St. Louis  
 St. Louis City Hospital, St. Louis  
 St. Louis City Hospital, No. 2, St. Louis  
 St. Louis Mullany Hospital, St. Louis  
 St. Luke's Hospital, Kansas City  
 St. Luke's Hospital, St. Louis  
 St. Mary's Infirmary, St. Louis  
 St. Mary's Hospital, Kansas City  
 50 to 100 beds  
 Boone County Hospital, Columbia  
 Frisco Employees Hospital, Springfield  
 Independence Sanitarium, Independence  
 Noyes Hospital, St. Joseph  
 St. Francis Hospital, Cape Girardeau  
 St. Francis Hospital, Maryville  
 St. John's Hospital, Joplin  
 St. Louis Baptist Hospital, St. Louis  
 St. Mary's Hospital, Jefferson City  
 \*Trinity Lutheran Hospital, Kansas City  
 University Hospital, Columbia  
 Wheatley Provident Hospital, Kansas City  
 55 to 50 beds  
 Barnard Free Skin and Cancer Hospital, St. Louis  
 St. Louis Maternity Hospital, St. Louis  
 MONTANA  
 100 or more beds  
 Columbus Hospital, Great Falls  
 Holy Rosary Hospital, Miles City  
 Montana Deaconess Hospital, Great Falls  
 Murray Hospital, Butte  
 St. James Hospital, Butte  
 St. Patrick's Hospital, Missoula  
 St. Vincent's Hospital, Billings  
 50 to 100 beds  
 \*Northern Pacific Beneficial Association Hospital, Glendive  
 Northern Pacific Beneficial Association Hospital, Missoula  
 St. Ann's Hospital, Anaconda  
 \*St. John's Hospital, Helena  
 \*St. Joseph's Hospital, Lewiston  
 \*St. Peter's Hospital, Helena

NEBRASKA  
 100 or more beds  
 Bishop Clarkson Memorial Hospital, Omaha  
 Nebraska Methodist Episcopal Hospital, Omaha  
 Nebraska Orthopedic Hospital, Lincoln  
 St. Elizabeth's Hospital, Lincoln  
 St. Francis Hospital, Grand Island  
 St. Joseph's Hospital, Omaha  
 St. Mary's Hospital, Columbus  
 University of Nebraska Hospital, Omaha  
 50 to 100 beds  
 Immanuel Hospital, Omaha  
 \*St. Joseph's Hospital, Alliance  
 Swedish Mission Hospital, Omaha  
 West Nebraska Hospital, Scottsbluff  
 Wise Memorial Hospital, Omaha  
 35 to 50 beds  
 \*Falls City Hospital, Falls City  
 NEVADA  
 50 to 100 beds  
 Elko General Hospital, Elko  
 St. Mary's Hospital, Reno  
 35 to 50 beds  
 \*Steptoe Valley Hospital, East Ely  
 NEW HAMPSHIRE  
 100 or more beds  
 \*St. Joseph's Hospital, Nashua  
 50 to 100 beds  
 Claremont Hospital, Claremont  
 Elliott Community Hospital, Keene  
 Elliott Hospital, Manchester  
 \*Laconia Hospital, Laconia  
 Mary Hitchcock Memorial Hospital, Hanover  
 \*Nashua Memorial Hospital, Nashua  
 Notre Dame Hospital, Manchester  
 Sacred Heart Hospital, Manchester  
 35 to 50 beds  
 \*Portsmouth Hospital, Portsmouth  
 NEW JERSEY  
 100 or more beds  
 Alexian Brothers Hospital, Elizabeth  
 All Soul's Hospital, Morristown  
 Atlantic City Hospital, Atlantic City  
 Bayonne Hospital and Dispensary, Bayonne  
 Christ Hospital, Jersey City  
 Cooper Hospital, Camden  
 Elizabeth General Hospital, Elizabeth  
 Englewood Hospital, Englewood  
 Hackensack Hospital, Hackensack  
 Jersey City Hospital, Jersey City  
 Mercer Hospital, Trenton  
 Monmouth Memorial Hospital, Long Branch  
 Morristown Memorial Hospital, Morristown  
 Mountainside Hospital, Montclair  
 Muhlenberg Hospital, Plainfield  
 Newark Beth Israel Hospital, Newark  
 Newark City Hospital, Newark  
 Newark Memorial Hospital, Newark  
 Newark Presbyterian Hospital, Newark  
 Orange Memorial Hospital, Newark  
 Passaic General Hospital, Passaic  
 Paterson General Hospital, Paterson  
 Perth Amboy City Hospital, Perth Amboy  
 St. Barnabas Hospital, Newark  
 St. Elizabeth's Hospital, Elizabeth  
 St. Francis Hospital, Jersey City  
 St. Francis Hospital, Trenton  
 \*St. Gerard's Italian Hospital, Newark  
 St. James Hospital, Newark  
 St. Joseph's Hospital, Paterson  
 St. Mary's Hospital, Hoboken  
 St. Mary's Hospital, Orange  
 St. Michael's Hospital, Newark  
 St. Mary's Hospital, Passaic  
 St. Peter's General Hospital, New Brunswick  
 West Jersey Homeopathic Hospital, Camden  
 50 to 100 beds  
 Ann May Memorial Hospital, Spring Lake  
 Homeopathic Hospital, Newark  
 Hospital for Women and Children, Newark  
 \*Irvington General Hospital, Irvington  
 Mariam and Nathan Barnert Memorial Hospital, Paterson  
 Middlesex General Hospital, New Brunswick  
 Newcomb Hospital, Vineland  
 Newark Eye and Ear Infirmary, Newark  
 North Hudson Hospital, Weehawken  
 Overlook Hospital, Summit  
 William McKinley Memorial Hospital, Trenton  
 35 to 50 beds  
 Babies' Hospital, Newark  
 \*Burlington County Hospital, Mt. Holly  
 NEW MEXICO  
 50 to 100 beds  
 St. Joseph's Hospital, Albuquerque  
 \*St. Mary's Hospital, Gallup  
 \*St. Mary's Hospital, Roswell  
 St. Vincent's Hospital, Santa Fe  
 NEW YORK  
 100 or more beds  
 Albany Hospital, Albany  
 Arnot-Ogden Memorial Hospital, Elmira  
 Auburn City Hospital, Auburn  
 Bellevue Hospital, New York City  
 Beth David Hospital, New York City  
 Beth Israel Hospital, New York City  
 Beth Moses Hospital, Brooklyn  
 Binghamton Hospital, Binghamton  
 Broad Street Hospital, New York City  
 Bronx Hospital, New York City  
 Brooklyn Hospital, Brooklyn  
 Brownsville and East New York Hospital, Brooklyn

Buffalo City Hospital, Buffalo  
 Buffalo General Hospital, Buffalo  
 Buffalo Hospital of Sisters of Charity, Buffalo  
 Bushwick Hospital, Brooklyn  
 Carson C. Peck Memorial Hospital, Brooklyn  
 Children's Hospital, Buffalo  
 Columbus Extension Hospital, New York City  
 Community Hospital, New York City  
 Coney Island Hospital, Brooklyn  
 Crouse-Irving Hospital, Syracuse  
 Cumberland Street Hospital, Brooklyn  
 Deaconess Home and Hospital, Buffalo  
 Ellis Hospital, Schenectady  
 Faxon Hospital, Utica  
 Fifth Avenue Hospital, New York City  
 Flower Hospital, New York City  
 Flushing Hospital and Dispensary, Flushing  
 Fordham Hospital, New York City  
 French Benevolent Society Hospital, New York City  
 Gouverneur Hospital, New York City  
 Graslands Hospital, Valhalla  
 Greenpoint Hospital, Brooklyn  
 Harlem Hospital, New York City  
 Highland Hospital, Rochester  
 Hospital of the Good Shepherd, Syracuse  
 Holy Family Hospital, Brooklyn  
 House of Good Samaritan, Watertown  
 Hospital for Deformities and Joint Diseases, New York City  
 \*Ithaca City Hospital, Ithaca  
 Jamaica Hospital, Richmond Hill  
 Jewish Hospital, Brooklyn  
 Jewish Maternity Hospital, New York City  
 Jewish Memorial Hospital, New York City  
 King's County Hospital, Brooklyn  
 Knickerbocker Hospital, New York City  
 Lawrence Hospital, Bronxville  
 Lebanon Hospital, New York City  
 Lenox Hill Hospital, New York City  
 Lincoln Hospital, New York City  
 Long Island College Hospital, Brooklyn  
 Lutheran Hospital of Manhattan, New York City  
 Manhattan Eye and Ear Hospital, New York City  
 Memorial Hospital for Cancer and Allied Diseases, New York City  
 Memorial Hospital, Albany  
 Methodist Episcopal Hospital, Brooklyn  
 Metropolitan Hospital, New York City  
 \*Millard Fillmore Hospital, Buffalo  
 Misericordia Hospital, New York City  
 Mt. St. Mary's Hospital, Niagara Falls  
 Mt. Sinai Hospital, New York City  
 Mt. Vernon Hospital, Mt. Vernon  
 Montefiore Hospital, New York City  
 Nassau Hospital, Mineola, Long Island  
 New Rochelle Hospital, New Rochelle  
 New York City Hospital, Blackwell's Island, New York City  
 New York Eye and Ear Infirmary, New York City  
 New York Foundling Home, New York City  
 New York Hospital, New York City  
 New York Infirmary for Women and Children, New York City  
 New York Nursery and Child's Hospital, New York City  
 New York Orthopedic Hospital, New York City  
 New York Orthopedic Hospital for Children, West Haverstraw  
 New York Polyclinic Hospital, New York City  
 New York Post Graduate Hospital, New York City  
 New York Hospital for Ruptured and Crippled, New York City  
 New York Skin and Cancer Hospital, New York City  
 Niagara Falls Memorial Hospital, Niagara Falls  
 Norwegian Lutheran Deaconess Hospital, Brooklyn  
 Olean General Hospital, Olean  
 Oneida County Hospital, Rome  
 Park Avenue Clinical Hospital, Rochester  
 Presbyterian Hospital, New York City  
 Prospect Heights Hospital, New York City  
 Rochester General Hospital, Rochester  
 Rochester Homeopathic Hospital, Rochester  
 Rockaway Beach Hospital and Dispensary, Rockaway Beach  
 Roosevelt Hospital, New York City  
 \*Sailors Snug Harbor Hospital, New Brighton  
 St. Catherine's Hospital, Brooklyn  
 St. Elizabeth's Hospital and Home, Utica  
 St. Francis Hospital, New York City  
 St. John's Brooklyn Hospital, Brooklyn  
 St. John's Hospital, Long Island  
 \*St. John's Riverside Hospital, Yonkers  
 St. Luke's Hospital, New York City  
 St. Luke's Hospital, Newburgh  
 \*St. Luke's Hospital, Utica  
 St. Mark's Hospital, New York City  
 St. Mary's Maternity Hospital, Buffalo  
 St. Mary's Free Hospital for Children, New York City  
 St. Mary's Hospital, Brooklyn  
 St. Mary's Hospital, Rochester  
 St. Peter's Hospital, Albany  
 St. Peter's Hospital, Brooklyn  
 St. Vincent's Hospital, New York City  
 St. Vincent's Hospital, West New Brighton  
 Samaritan Hospital, Troy

Saratoga Hospital, Saratoga Springs  
 Sloane Hospital for Women, New York City  
 Soldiers and Sailors Memorial Hospital, Utica  
 Staten Island Hospital, Tompkinsville  
 Syracuse Memorial Hospital, Syracuse  
 The Sanitarium, Clifton Springs  
 Troy Hospital, Troy  
 United Hospital, Port Chester  
 United Israel Zion Hospital, Brooklyn  
 Vassar Brothers Hospital, Poughkeepsie  
 White Plains Hospital, White Plains  
 Woman's Hospital, New York City  
 Wyckoff Heights Hospital, Brooklyn  
 Yonkers Homeopathic Hospital and Maternity Home, Yonkers  
 50 to 100 beds  
 Alice Hyde Memorial Hospital, Malone  
 Amsterdam City Hospital, Amsterdam  
 \*Anthony Brady Hospital, Albany  
 \*Aurelia Osborne Fox Memorial Hospital, Oneonta  
 Babies Hospital, New York City  
 Beekman Street Hospital, New York City  
 Benedictine Hospital, Kingston  
 \*Bethesda Hospital, Hornell  
 Broad Street Hospital, Oneida  
 Brooklyn Eye and Ear Hospital, Brooklyn  
 City Hospital, Kingston  
 Columbus Hospital, New York City  
 Dobbs Ferry Hospital, Dobbs Ferry  
 Emergency Hospital of Sisters of Charity, Buffalo  
 General Hospital, Syracuse  
 \*Geneva City Hospital, Geneva  
 Glens Falls Hospital, Glens Falls  
 Harbor Hospital, Brooklyn  
 \*Herman Knapp Memorial Eye Hospital, New York City  
 Hudson City Hospital, Hudson  
 \*Italian Benevolent Hospital, New York City  
 Lee Private Hospital, Rochester  
 Leonard Hospital, Troy  
 Manhattan Maternity Hospital, New York City  
 Mary Immaculate Hospital, Jamaica  
 Mary McClellan Hospital, Cambridge  
 \*Mercy Hospital, Watertown  
 Nathan Littauer Hospital, Gloversville  
 Neurological Institute, New York City  
 New York Ophthalmic Hospital, New York City  
 Ossining Hospital, Ossining  
 \*Oswego Hospital, Oswego  
 Rockefeller Institute, New York City  
 Reconstruction Hospital, New York City  
 Rome Hospital, Rome  
 St. Bartholomew's Hospital, New York City  
 \*St. Francis Hospital, Poughkeepsie  
 St. James Mercy Hospital, Hornell  
 \*St. Jerome's Hospital, Batavia  
 \*St. Joseph's Hospital, Syracuse  
 St. Joseph's Hospital, Yonkers  
 \*St. Mary's Hospital, Amsterdam  
 Southampton Hospital, Southampton  
 Southside Hospital, Bayshore  
 Swedish Hospital, Brooklyn  
 Woman's Christian Association Hospital, Jamestown  
 \*Wyoming County Hospital, Warsaw  
 55 to 50 beds  
 Greenwich Hospital, Greenwich  
 Lexington Hospital, New York City  
 \*Soldier's and Sailor's Memorial Hospital, Pennsylvania  
 NORTH CAROLINA  
 100 or more beds  
 City Memorial Hospital, Winston-Salem  
 Rex Hospital, Raleigh  
 St. Leo's Hospital, Greensboro  
 Watts Hospital, Durham  
 50 to 100 beds  
 Atlantic Coast Lines R. R. Hospital, Rocky Mount  
 Biltmore Hospital, Biltmore  
 French Broad Hospital, Asheville  
 Highpoint Hospital, Highpoint  
 Highsmith Hospital, Fayetteville  
 Lawrence Hospital, Winston-Salem  
 Lincoln Hospital, Lincolnton  
 Long's Sanitarium, Statesville  
 Martin Memorial Hospital, Mt. Airy  
 \*Mercy General Hospital, Charlotte  
 New Charlotte Sanitarium, Charlotte  
 \*North Carolina Baptist Hospital, Winston-Salem  
 North Carolina Orthopedic Hospital, Gastonia  
 Parkview Hospital, Rocky Mount  
 Pitt Community Hospital, Greenville  
 Pittman Hospital, Fayetteville  
 Rutherford Hospital, Rutherfordton  
 \*Salisbury Hospital, Salisbury  
 35 to 50 beds  
 Bullock Hospital, Wilmington  
 Cumberland General Hospital, Fayetteville  
 \*More Heiring Hospital, Wilson  
 \*Parrott Memorial Hospital, Ringston  
 Richard Baker Hospital, Hickory  
 \*Rocky Mount Sanitarium, Rocky Mount  
 \*Shelby Hospital, Shelby  
 Wesley Long Hospital, Greensboro  
 NORTH DAKOTA  
 100 or more beds  
 Bismarck Evangelical Deaconess Hospital, Bismarck

Grand Forks Deaconess Hospital, Grand Forks  
 St. Alexius Hospital, Bismarck  
 St. John's Hospital, Fargo  
 St. Luke's Hospital, Fargo  
 50 to 100 beds  
 \*St. Joseph's Hospital, Minot  
 St. Michael's Hospital, Grand Forks  
 OHIO  
 100 or more beds  
 Alliance Hospital, Alliance  
 Aultman Hospital, Canton  
 Bethesda Hospital, Cincinnati  
 Bethesda Hospital, Zanesville  
 Christ Hospital, Cincinnati  
 Cincinnati General Hospital, Cincinnati  
 City Hospital, Akron  
 Cleveland City Hospital, Cleveland  
 Cleveland Clinic Hospital, Cleveland  
 Cleveland Maternity Hospital, Cleveland  
 Glenville Hospital, Cleveland  
 Good Samaritan Hospital, Cincinnati  
 Good Samaritan Hospital, Zanesville  
 Grant Hospital, Columbus  
 Hawkes Hospital of Mt. Carmel, Columbus  
 Huron Road Hospital, Cleveland  
 Jewish Hospital, Cincinnati  
 Lakeside Hospital, Cleveland  
 Lucas County Hospital, Toledo  
 Lutheran Hospital, Cleveland  
 Massillon City Hospital, Massillon  
 Mercy Hospital, Hamilton  
 Mercy Hospital, Toledo  
 Miami Valley Hospital, Dayton  
 Middleton Hospital, Middleton  
 Mt. Sinai Hospital, Cleveland  
 Portsmouth General Hospital, Portsmouth  
 St. Alexia Hospital, Cleveland  
 St. Ann's Infant Asylum and Maternity Hospital, Cleveland  
 St. Elizabeth's Hospital, Dayton  
 St. Elizabeth's Hospital, Youngstown  
 St. Francis Hospital, Columbus  
 St. John's Hospital, Cleveland  
 St. Joseph's Hospital, Lorain  
 St. Luke's Hospital, Cleveland  
 St. Mary's Hospital, Cincinnati  
 St. Rita's Hospital, Lima  
 St. Vincent's Hospital, Cleveland  
 St. Vincent's Hospital, Toledo  
 Springfield City Hospital, Springfield  
 Toledo Hospital, Toledo  
 Youngstown Hospital, Youngstown  
 White Cross Hospital, Columbus  
 Woman's Hospital, Cleveland  
 50 to 100 beds  
 Bellaire City Hospital, Bellaire  
 Children's Hospital, Cincinnati  
 Children's Hospital, Columbus  
 Deaconess Hospital, Cincinnati  
 Fairview Hospital, Cleveland  
 Flower Hospital, Toledo  
 Good Samaritan Hospital, Sandusky  
 Holzer Hospital, Gallipolis  
 \*Home and Hospital of City of Finley, Finley  
 Hospital Clinic Company, Cleveland  
 Lakewood Hospital, Lakewood  
 Lima City Hospital, Lima  
 Mansfield General Hospital, Mansfield  
 Martin's Ferry Hospital, Martin's Ferry  
 Mary Day Nursery and Children's Hospital, Akron  
 Maternity and Children's Hospital, Toledo  
 Memorial Hospital, Tremont  
 Mercy Hospital Columbus  
 Mercy Hospital, Canton  
 Newark City Hospital, Newark  
 \*Ohio Valley Hospital, Steubenville  
 Robinwood Hospital, Toledo  
 \*St. Anne's Infant Asylum Hospital, Columbus  
 Salem Hospital, Salem  
 Schirman Hospital, Portsmouth  
 University Hospital, Columbus  
 Warren City Hospital, Warren  
 Grace Hospital, Cleveland  
 \*Mithoefer Hospital, Cincinnati  
 OKLAHOMA  
 100 or more beds  
 St. Anthony's Hospital, Oklahoma City  
 State University Hospital, Oklahoma City  
 50 to 100 beds  
 Morningside Hospital, Tulsa  
 \*Oklahoma Baptist Hospital, Muskogee  
 Wesley Hospital, Oklahoma City  
 55 to 50 beds  
 \*Ponca City Hospital, Ponca City  
 OREGON  
 100 or more beds  
 Emanuel Hospital, Portland  
 Good Samaritan Hospital, Portland  
 Multnomah County Hospital, Portland  
 Portland Sanitarium, Portland  
 St. Vincent's Hospital, Portland  
 50 to 100 beds  
 Eugene Hospital, Eugene  
 \*Mercy Hospital, Eugene  
 \*Pacific Christian Hospital, Eugene  
 Portland Surgical Hospital, Portland  
 Sacred Heart Hospital, Medford  
 St. Mary's Hospital, Astoria  
 \*Salem City Hospital, Salem  
 PENNSYLVANIA  
 100 or more beds  
 Abington Hospital, Abington  
 Allegheny General Hospital, Pittsburgh  
 Allentown Hospital, Allentown  
 Altoona Hospital, Altoona  
 Ashland State Hospital, Ashland  
 Braddock General Hospital, Braddock  
 Bradford Hospital, Bradford  
 Bryn Mawr Hospital, Bryn Mawr  
 Chambersburg Hospital, Chambersburg  
 Chester County Hospital, West Chester  
 Chester Hospital, Chester  
 Chestnut Hill Hospital, Philadelphia  
 Children's Hospital, Philadelphia  
 Children's Homeopathic Hospital, Philadelphia  
 \*Christian H. Buhl Hospital, Sharon  
 Clearfield Hospital, Clearfield  
 Columbia Hospital, Pittsburgh  
 Conemaugh Valley Memorial Hospital, Johnstown  
 Easton Hospital, Easton  
 Elizabeth Steel Magee Hospital, Pittsburgh  
 Frankford Hospital, Philadelphia  
 George F. Geisinger Hospital, Danville  
 Germantown Dispensary and Hospital, Philadelphia  
 Hahnemann Hospital, Scranton  
 Hahnemann Medical and Surgical Hospital, Philadelphia  
 Hamot Hospital, Erie  
 Harrisburg Hospital, Harrisburg  
 Hazleton State Hospital, Hazleton  
 Homeopathic Medical and Surgical Hospital, Pittsburgh  
 Hospital of the Protestant Episcopal Church, Philadelphia  
 Hospital of the University of Pennsylvania, Philadelphia  
 Hospital of the Woman's Medical College, Philadelphia  
 J. Lewis Crozer Hospital, Chester  
 Jefferson Hospital, Philadelphia  
 Jewish Hospital, Philadelphia  
 Lancaster General Hospital, Lancaster  
 Lankenau Hospital, Philadelphia  
 Medical Chirurgical and Polyclinic Hospitals, Philadelphia  
 Memorial Hospital, Roxborough  
 Mercy Hospital, Altoona  
 Mercy Hospital, Johnstown  
 Mercy Hospital, Philadelphia  
 Mercy Hospital, Pittsburgh  
 Mercy Hospital, Wilkes-Barre  
 Methodist Episcopal Hospital, Philadelphia  
 Misericordia Hospital, Philadelphia  
 \*Montgomery Hospital, Norristown  
 Moses Taylor Hospital, Scranton  
 Mt. Sinai Hospital, Philadelphia  
 \*Nanticoke State Hospital, Nanticoke  
 Passavant Hospital, Pittsburgh  
 Pennsylvania Hospital, Philadelphia  
 Philadelphia General Hospital, Philadelphia  
 Philipsburg State Hospital, Philipsburg  
 Pittsburgh City Home and Hospital, Mayview  
 Pittsburgh Hospital, Pittsburgh  
 Pottsville Hospital, Pottsville  
 Presbyterian Hospital, Philadelphia  
 Presbyterian Hospital, Pittsburgh  
 Reading Hospital, Reading  
 Robert Packer Hospital, Sayre  
 \*Rochester General Hospital, Rochester  
 Sacred Heart Hospital, Allentown  
 St. Agnes Hospital, Philadelphia  
 St. Francis Hospital, Pittsburgh  
 St. John's General Hospital, Pittsburgh  
 St. Joseph's Hospital, Lancaster  
 St. Joseph's Hospital, Philadelphia  
 St. Joseph's Hospital, Pittsburgh  
 St. Joseph's Hospital, Reading  
 \*St. Joseph's Infant and Maternity Hospital, Scranton  
 St. Luke's Hospital, South Bethlehem  
 St. Margaret's Hospital, Pittsburgh  
 St. Mary's Hospital, Philadelphia  
 St. Vincent's Hospital, Erie  
 Samaritan Hospital, Philadelphia  
 Scranton State Hospital, Scranton  
 South Side Hospital, Pittsburgh  
 Uniontown Hospital, Uniontown  
 Washington Hospital, Washington  
 West Philadelphia Hospital for Women, Philadelphia  
 Western Pennsylvania Hospital, Pittsburgh  
 \*Westmoreland Hospital, Greensburg  
 Wilkes-Barre City Hospital, Wilkes-Barre  
 Williamsport Hospital, Williamsport  
 Willis Hospital, Philadelphia  
 Women's Homeopathic Hospital, Philadelphia  
 Woman's Hospital, Philadelphia  
 York Hospital and Dispensary, York  
 50 to 100 beds  
 \*Adrian Hospital, Punxsutawney  
 Annie M. Warner Hospital, Gettysburg  
 Beaver Valley General Hospital, New Brighton  
 Bloomsburg Hospital, Bloomsburg  
 Cambria Hospital, Johnstown  
 \*Carlisle General Hospital, Carlisle  
 Children's Hospital, Pittsburgh  
 Children's Hospital of the Mary J. Drexel Home, Philadelphia  
 Citizens General Hospital, New Kensington  
 Columbia Hospital, Columbia  
 Cottage State Hospital, Bloomsburg  
 DuBois Hospital, DuBois  
 Eye and Ear Hospital, Pittsburgh

Frederick Douglass Memorial Hospital, Philadelphia

Good Samaritan Hospital, Lebanon

Homeopathic Hospital, West Chester

Homestead Hospital, Homestead

Howard Hospital, Philadelphia

Indiana Hospital, Indiana

J. C. Blair Memorial Hospital, Huntingdon

Jewish Maternity Hospital, Philadelphia

Joseph Price Memorial Hospital, Philadelphia

\*Kane Summitt Hospital, Kane

Kensington Hospital for Women, Philadelphia

Lock Haven Hospital, Lock Haven

Maple Avenue Hospital, Du Bois

\*Memorial Hospital, New Eagle

Montefiore Hospital, Pittsburgh

\*Nesbitt State Hospital, Kingston

New Castle Hospital, New Castle

\*Ohio Valley Hospital, McKees Rocks

Oil City Hospital, Oil City

Palmerton Hospital, Palmerton

Philadelphia Lying-in Charity Hospital, Philadelphia

Pittston Hospital, Pittston

Polyclinic Hospital, Harrisburg

Providence Hospital, Beaver Falls

Rosella Foundling and Maternity Hospital, Pittsburgh

\*St. Christopher Hospital for Children, Philadelphia

St. Luke's Homeopathic Hospital, Philadelphia

St. Vincent's Hospital, Philadelphia

\*Sewickley Valley Hospital, Sewickley

Shamokin Hospital, Shamokin

Stetson Hospital, Philadelphia

Suburban Hospital, Bellevue

\*West Philadelphia Hospital, Philadelphia

Windber Hospital, Windber

35 to 50 beds

Great Heart Maternity Hospital, Philadelphia

Lee Homeopathic Hospital, Johnstown

West Side Sanitarium, York

**RHODE ISLAND**

100 or more beds

Homeopathic Hospital, Providence

Newport Hospital, Newport

Providence City Hospital, Providence

Rhode Island Hospital, Providence

St. Joseph's Hospital, Providence

50 to 100 beds

\*Memorial Hospital, Pawtucket

Providence Lying-in Hospital, Providence

**SOUTH CAROLINA**

100 or more beds

Columbia Hospital, Columbia

Florence Infirmary, Florence

Greenville City Hospital, Greenville

Roper Hospital, Charleston

South Carolina Baptist Hospital, Columbia

50 to 100 beds

Anderson County Hospital, Anderson

Baker Sanatorium, Charleston

St. Francis Xavier Infirmary, Charleston

35 to 50 beds

\*Mary Black Clinic and Hospital, Spartanburg

Orangeburg Hospital, Orangeburg

University Hospital, Anderson

**SOUTH DAKOTA**

100 or more beds

Chamberlain Sanitarium and Hospital, Chamberlain

McKenna Hospital, Sioux Falls

Methodist State Hospital, Mitchell

Sacred Heart Hospital, Yankton

St. Luke's Hospital, Aberdeen

50 to 100 beds

Bartron Hospital, Watertown

Lincoln Hospital, Aberdeen

Luther Hospital, Watertown

Lutheran Hospital, Hot Springs

Moe Hospital, Sioux Falls

New Madison Hospital, Madison

Peabody Hospital, Webster

St. Joseph's Hospital, Mitchell

St. Mary's Hospital, Pierre

**TENNESSEE**

100 or more beds

Baptist Memorial Hospital, Memphis

Erlanger Hospital, Chattanooga

George W. Hubbard Hospital, Nashville

Knoxville General Hospital, Knoxville

Memphis General Hospital, Memphis

Methodist Hospital, Memphis

Nashville City Hospital, Nashville

St. Joseph's Hospital, Memphis

St. Thomas Hospital, Nashville

Vanderbilt Hospital, Nashville

50 to 100 beds

Appalachian Hospital, Johnson City

Baird-Dulaney Hospital, Dyersburg

Baptist Hospital, Nashville

\*Millie E. Hale Hospital, Nashville

Newell and Newell Sanitarium, Chattanooga

Protestant Hospital, Nashville

Riverside Hospital, Knoxville

Woman's Hospital, Memphis

35 to 50 beds

Crippled Children's Hospital, Memphis

TEXAS

100 or more beds

Baylor Hospital, Dallas

Baptist Hospital, Houston

Central Texas Baptist Sanitarium, Waco

Harris Hospital, Fort Worth

Hotel Dieu, Beaumont

International R. R. Hospital, Palestine

\*Jefferson Davis Hospital, Houston

John Sealy Hospital, Galveston

Methodist Hospital, Houston

Parkland Hospital, Dallas

Providence Sanitarium, Waco

Robert B. Green Memorial Hospital, San Antonio

St. Joseph's Infirmary, Fort Worth

St. Joseph's Infirmary, Houston

St. Mary's Infirmary, Galveston

St. Paul's Sanitarium, Dallas

Santa Fe Hospital, Temple

Santa Rosa Infirmary, San Antonio

Scott and White Hospital, Temple

Seton Infirmary, Austin

Southern Pacific Hospital, Houston

Wichita General Hospital, Wichita Falls

50 to 100 beds

All Saints' Hospital, Fort Worth

\*Baptist Hospital, Fort Worth

City and County Hospital, Fort Worth

Frances Ann Lutcher Hospital, Orange

Hella Temple Hospital, Dallas

King's Daughters Hospital, Temple

Masonic Hospital, El Paso

St. Anthony's Hospital, Amarillo

\*St. Joseph's Hospital, Paris

Sanatorium of Paris, Paris

Sherman Hospital, Sherman

Spohn Sanitarium, Corpus Christi

Texarkana Sanitarium, Texarkana

Texas and Pacific R. R. Hospital, Marshall

35 to 50 beds

Burns Hospital, Cuero

\*Children's Hospital, Fort Worth

Colgin Hospital, Waco

McKinney City Hospital, McKinney

UTAH

100 or more beds

Doctor W. H. Groves Latter Day Saints' Hospital, Salt Lake City

Holy Cross Hospital, Salt Lake City

St. Mark's Hospital, Salt Lake City

Salt Lake County Hospital, Salt Lake City

Thomas D. Dee Memorial Hospital, Ogden

50 to 100 beds

Utah-Idaho Hospital, Logan

VERMONT

100 or more beds

Bishop de Goss Briand Hospital, Burlington

Mary Fletcher Hospital, Burlington

50 to 100 beds

Fanny Allen Hospital, Winona

Heaton Hospital, Montpelier

Rutland Hospital, Rutland

\*St. Albans Hospital, St. Albans

VIRGINIA

100 or more beds

Chesapeake and Ohio Hospital, Clifton Forge

Hospital Division of Medical College of Virginia, Richmond

Norfolk Protestant Hospital, Norfolk

Retreat for the Sick, Richmond

Roanoke Hospital, Roanoke

St. Vincent's Hospital, Norfolk

Stuart Circle Hospital, Richmond

University of Virginia Hospital, Charlottesville

50 to 100 beds

\*Dixie Hospital and Hampton Training School for Nurses, Hampton

Elizabeth Buxton Hospital, Newport News

George Ben Johnston Memorial Hospital, Abingdon

Grace Hospital, Richmond

Jefferson Hospital, Roanoke

Johnston-Willis Sanitarium, Richmond

King's Daughters Hospital, Staunton

\*King's Daughters Hospital, Portsmouth

Lake View Hospital, Suffolk

Lewis Gale Hospital, Roanoke

\*Lynchburg Hospital and City Home, Lynchburg

Parrish Memorial Hospital, Portsmouth

\*Petersburg Hospital, Petersburg

\*Riverside Hospital, Newport News

St. Elizabeth's Hospital, Richmond

St. Luke's Hospital, Richmond

Sarah Leigh Hospital, Norfolk

\*Sheltering Arms Free Hospital, Richmond

Shenandoah Hospital, Roanoke

Tucker Sanitarium, Richmond

Virginia Baptist Hospital, Lynchburg

Winchester Memorial Hospital, Winchester

WASHINGTON

100 or more beds

Children's Orthopedic Hospital, Seattle

Columbus Sanitarium, Seattle

King County Hospital, Seattle

Maria Beard Deaconess Hospital, Spokane

\*Northern Pacific Hospital, Tacoma

\*Providence Hospital, Everett

Providence Hospital, Seattle

Sacred Heart Hospital, Spokane

\*St. Elizabeth's Hospital, Yakima

St. Joseph's Hospital, Tacoma

St. Luke's Hospital, Spokane

St. Mary's Hospital, Walla Walla

Seattle City Hospital, Seattle

Seattle General Hospital, Seattle

Swedish Hospital, Seattle

Tacoma General Hospital, Tacoma

50 to 100 beds

Everett General Hospital, Everett

Minor Private Hospital, Seattle

\*St. Anthony's Hospital, Wenatchee

\*St. Joseph's Hospital, Aberdeen

St. Joseph's Hospital, Bellingham

St. Luke's Hospital, Seattle

Virginia Mason Hospital, Seattle

Walla Walla Sanitarium, College Place

35 to 50 beds

\*Norwegian Hospital, Seattle

Walla Walla Sanitarium, Walla Walla

WEST VIRGINIA

100 or more beds

Charleston General Hospital, Charleston

Kessler Hatfield Hospital, Huntington

\*Logan Hospital, Logan

Mountain State Hospital, Charleston

Ohio Valley Hospital, Wheeling

\*St. Francis Hospital, Charleston

St. Mary's Hospital, Clarksburg

Welch Hospital, No. 1, Welch

Wheeling Hospital, Wheeling

50 to 100 beds

Beckley Hospital, Beckley

Bluefield Sanitarium, Bluefield

\*Camden Clark Hospital, Parkersburg

\*Chesapeake and Ohio R. R. Hospital, Huntington

100 or more beds

Columbia Hospital, Milwaukee

Evangelical Deaconess Hospital, Milwaukee

Holy Family Hospital, Manitowoc

LaCrosse Lutheran Hospital, LaCrosse

Lutheran Hospital, Eau Claire

Madison General Hospital, Madison

Marquette University Hospital, Milwaukee

Mercy Hospital, Janesville

Milwaukee County Hospital, Milwaukee

Milwaukee Hospital, Milwaukee

St. Agnes Hospital, Fond du Lac

St. Elizabeth's Hospital, Appleton

St. Francis Hospital, LaCrosse

St. Joseph's Hospital, Marshfield

St. Joseph's Hospital, Milwaukee

\*St. Mary's Hospital, Green Bay

St. Mary's and Mercy Hospitals, Oshkosh

St. Mary's

Shaughnessy Hospital, Vancouver  
Vancouver General Hospital, Vancouver  
50 to 100 beds  
Queen Victoria Hospital, Revelstoke  
MANITOBA  
100 or more beds  
Brandon General Hospital, Brandon  
Children's Hospital, Winnipeg  
Grace Hospital, Winnipeg  
King Edward Hospital, Winnipeg  
King George Hospital, Winnipeg  
Misericordia Hospital, Winnipeg  
St. Boniface Hospital, St. Boniface  
\*Victoria Hospital, Winnipeg  
Winnipeg General Hospital, Winnipeg  
NEW BRUNSWICK  
100 or more beds  
General Public Hospital, St. John  
Lacaster Hospital, St. John  
St. John County Hospital, East St. John  
50 to 100 beds  
Chipman Memorial Hospital, St. Stephen  
Hotel Dieu, Campbellton  
Hotel Dieu, Chatham  
\*Hotel Dieu, St. Basil  
Maramichi Hospital, New Castle  
Moncton Hospital, Moncton  
St. John's Infirmary, St. John  
Soldiers Memorial Hospital, Campbellton  
Victoria Public Hospital, Fredericton  
35 to 50 beds  
L. P. Fisher Memorial Hospital, Woodstock  
NOVA SCOTIA  
100 or more beds  
St. Joseph's Hospital, Glace Bay  
Victoria Hospital, Halifax  
50 to 100 beds  
\*Aberdeen Hospital, New Glasgow  
Children's Hospital, Halifax  
General Hospital, Glace Bay  
Grace Maternity Hospital, Halifax  
Halifax Infirmary, Halifax  
Highland View Hospital, Amherst  
St. Martha's Hospital, Antigonish  
Sydney City Hospital, Sydney  
Yarmouth Hospital, Yarmouth  
ONTARIO  
100 or more beds  
\*General Hospital, Belleville  
Brantford General Hospital, Brantford  
\*General Hospital, Brockville  
General Hospital, Kingston  
General Hospital, Sault Ste. Marie  
General Hospital, Toronto  
Grace Hospital, Toronto  
Hamilton General Hospital, Hamilton  
Hotel Dieu, Kingston  
Hotel Dieu, Windsor  
McKellar General Hospital, Ft. William  
Ottawa Civic Hospital, Ottawa  
Ottawa General Hospital, Ottawa  
St. Joseph's Hospital, Hamilton  
St. Joseph's Hospital, London  
St. Joseph's Hospital, Port Arthur  
St. Joseph's Hospital, Sudbury  
St. Michael's Hospital, Toronto  
\*St. Vincent de Paul Hospital, Brockville  
Sick Children's Hospital, Toronto  
Stratford General Hospital, Stratford  
Western Hospital, Toronto  
Victoria Hospital, London  
Wellesley Hospital, Toronto  
50 to 100 beds  
\*General Hospital, Galt  
\*General Hospital, St. Catherines  
Niagara Falls Memorial Hospital, Niagara Falls  
Nicholls Hospital, Petersboro  
Oshawa General Hospital, Oshawa  
Owen Sound General and Marine Hospital, Owen Sound  
\*Public Hospital, Smith Falls  
St. Francis Hospital, Smith Falls  
St. Joseph's Hospital, Peterboro  
\*Salvation Army Hospital, Ottawa  
\*Welland County Hospital, Welland  
Women's College Hospital, Toronto  
PRINCE EDWARD ISLAND  
50 to 100 beds  
Charlottetown Hospital, Charlottetown  
Prince Edward Island Hospital, Charlottetown  
Princes County Hospital, Summerside  
QUEBEC  
100 or more beds  
Children's Memorial Hospital, Montreal  
De La Misericordia Hospital, Montreal  
General St. Vincent Hospital, Sherbrooke  
Hotel Dieu, Montreal  
Jeffery Hale's Hospital, Quebec  
Montreal General Hospital, Montreal  
Notre Dame Hospital, Montreal  
Royal Victoria Hospital, Montreal  
Sainte Justine Pour Les Enfants, Montreal  
50 to 100 beds  
\*Homeopathic Hospital, Montreal  
Montreal Foundling and Baby Hospital, Montreal  
Montreal Maternity Hospital, Montreal  
\*St. Francois d' Assise, Quebec  
Sherbrooke Hospital, Sherbrooke  
Shriner's Hospital, Montreal

SASKATCHEWAN  
100 or more beds  
Grey Nun's Hospital, Regina  
Moose Jaw General Hospital, Moose Jaw  
St. Paul's Hospital, Saskatoon  
Saskatoon City Hospital, Saskatoon  
50 to 100 beds  
Holy Family Hospital, Prince Albert  
\*Hugh Waddell Memorial Hospital, Canora  
Notre Dame Hospital, North Battleford  
Providence Hospital, Moose Jaw  
\*St. Elizabeth's Hospital, Humboldt  
Victoria Hospital, Prince Albert  
AUSTRALIA  
Royal Alexandra Hospital for Children, Sydney, New South Wales  
CANAL ZONE  
Aneon Hospital, Ancon  
CHINA  
Hunan-Yale Hospital, Changsha  
FRANCE  
\*American Hospital, Paris  
HAWAII  
Queen's Hospital, Honolulu  
PORTO RICO  
Presbyterian Hospital, San Juan  
NEW ZEALAND  
Dunedin Hospital, Dunedin  
URUGUAY  
Gynecological Hospital (Pereira Rossell), Montevideo  
Maternity Hospital (Pereira Rossell), Montevideo  
American College of Surgeons  
UNITED STATES GOVERNMENT  
ARMY  
Fitzsimmons General Hospital, Denver, Colorado  
Letterman General Hospital, San Francisco, California  
Station Hospital, Fort Sam Houston, Texas  
Walter Reed General Hospital, Washington, District of Columbia  
William Beaumont Hospital, El Paso, Texas  
NAVY  
United States Naval Hospital, Mare Island, California  
United States Naval Hospital, San Diego, California  
United States Naval Relief Ship, San Pedro, California  
United States Naval Hospital, Great Lakes, Illinois  
United States Naval Hospital, Chelsea, Massachusetts  
United States Naval Hospital, Washington, District of Columbia  
United States Naval Hospital, League Island, Philadelphia, Pennsylvania  
United States Naval Hospital, Norfolk, Virginia  
PUBLIC HEALTH  
United States Marine Hospital No. 1, Baltimore, Maryland  
United States Marine Hospital, No. 2, Boston, Massachusetts  
United States Marine Hospital No. 3, Buffalo, New York  
United States Marine Hospital No. 5, Chicago, Illinois  
United States Marine Hospital No. 6, Cleveland, Ohio  
\*United States Marine Hospital No. 7, Detroit, Michigan  
\*United States Marine Hospital No. 8, Evansville, Indiana  
United States Marine Hospital No. 9, Fort Stanton, New Mexico  
\*United States Marine Hospital No. 10, Key West, Florida  
United States Marine Hospital No. 11, Louisville, Kentucky  
United States Marine Hospital No. 12, Memphis, Tennessee  
United States Marine Hospital No. 13, Mobile, Alabama  
United States Marine Hospital No. 14, New Orleans, Louisiana  
\*United States Marine Hospital No. 15, Pittsburgh, Pennsylvania  
\*United States Marine Hospital No. 17, Port Townsend, Washington  
United States Marine Hospital No. 18, St. Louis, Missouri  
United States Marine Hospital No. 19, San Francisco, California  
United States Marine Hospital No. 20, Savannah, Georgia  
United States Marine Hospital No. 21, Stapleton, New York  
United States Marine Hospital No. 43, Ellis Island, New York

United States Marine Hospital No. 66, Carville, Louisiana  
United States Marine Hospital No. 70, New York, New York  
United States Marine Hospital No. 82, Norfolk, Virginia

## VETERANS

United States Veterans' Hospital No. 24, Palo Alto, California  
United States Veterans' Hospital No. 27, Alexandria, Louisiana  
United States Veterans' Hospital No. 32, Washington, District of Columbia  
United States Veterans' Hospital No. 37, Waukesha, Wisconsin  
United States Veterans' Hospital No. 41, New Haven, Connecticut  
United States Veterans' Hospital No. 42, Perry Point, Md.  
United States Veterans' Hospital No. 44, West Roxbury, Massachusetts  
United States Veterans' Hospital No. 48, Atlanta, Georgia  
United States Veterans' Hospital No. 49, Philadelphia, Pennsylvania  
United States Veterans' Hospital No. 50, Whipple Barracks, Arizona  
United States Veterans' Hospital No. 51, Tucson, Arizona  
United States Veterans' Hospital No. 52, Boise, Idaho  
United States Veterans' Hospital No. 53, Dwight, Illinois  
United States Veterans' Hospital No. 55, Fort Bayard, New Mexico  
United States Veterans' Hospital No. 57, Knoxville, Iowa  
United States Veterans' Hospital No. 59, Tacoma, Washington  
United States Veterans' Hospital No. 60, Oteen, North Carolina  
United States Veterans' Hospital No. 62, Augusta, Georgia  
United States Veterans' Hospital No. 63, Lake City, Florida  
United States Veterans' Hospital No. 64, Camp Kearney, California  
United States Veterans' Hospital No. 65, St. Paul, Minnesota  
United States Veterans' Hospital No. 67, Kansas City, Missouri  
United States Veterans' Hospital No. 68, Minneapolis, Minnesota  
United States Veterans' Hospital No. 69, Fort Thomas, Kentucky  
United States Veterans' Hospital No. 72, Helena, Montana  
United States Veterans' Hospital No. 74, Gulfport, Mississippi  
Edward Hines Junior Hospital, Maywood, Illinois  
United States Veterans' Hospital No. 77, Portland, Oregon  
United States Veterans' Hospital No. 78, North Little Rock, Arkansas  
United States Veterans' Hospital No. 79, Dawson Springs, Kentucky  
United States Veterans' Hospital No. 81, Bronx, New York  
United States Veterans' Hospital No. 84, Algiers, Louisiana  
United States Veterans' Hospital No. 85, Walla Walla, Washington  
United States Veterans' Hospital No. 88, Memphis, Tennessee  
United States Veterans' Hospital No. 89, Rutland, Massachusetts  
United States Veterans' Hospital No. 90, Muskogee, Oklahoma  
\*United States Veterans' Hospital No. 91, Tuskegee, Alabama  
United States Veterans' Hospital No. 92, Jefferson Barracks, Missouri  
United States Veterans' Hospital No. 93, Legion, Texas  
United States Veterans' Hospital No. 94, American Lake, Washington  
United States Veterans' Hospital No. 95, Northampton, Massachusetts  
\*United States Veterans' Hospital No. 96, Tupper Lake, New York  
United States Veterans' Hospital No. 97, Chillicothe, Ohio  
United States Veterans' Hospital No. 98, Castle Point, New York  
United States Veterans' Hospital No. 100, Camp Custer, Michigan  
United States Veterans' Hospital No. 101, St. Cloud, Minnesota  
United States Veterans' Hospital No. 102, Livermore, California  
NATIONAL SANATORIUMS—  
National Sanitarium, Sawtelle, California  
National Sanitarium, Danville, Illinois  
National Sanitarium, Togus, Maine  
National Sanitarium, Leavenworth, Kansas  
National Sanitarium, Dayton, Ohio  
National Sanitarium, Johnson City, Tennessee  
\*National Sanitarium, Hot Springs, South Dakota  
National Sanitarium, Hampton, Virginia  
National Sanitarium, National Home, Wisconsin

## WISCONSIN HOLDS ANNUAL CONVENTION

**W**ITH an exceptionally good program of interesting discussions and papers the Wisconsin Hospital Association held a three-day meeting at the Pfister Hotel, Milwaukee, November 17, 18 and 19. The total registration of delegates and guests was well over 60 and hospital people from Madison, La Crosse, Eau Claire, Neenah and other parts of the state besides those residing in the city where the convention was held were present.

In connection with the sessions there was an exhibit of hospital supplies staged by manufacturers. This exhibit proved to be successful through the many visitations made by those attending the meeting, and many expressions of satisfaction were forthcoming from the exhibitors.

Rev. Arthur S. Beale of the Congregational Church, Milwaukee, opened the meeting on Tuesday afternoon by invocation. He was followed by an address of welcome on behalf of the mayor of Milwaukee, the Honorable Daniel Hoan, which was delivered by Dr. A. C. Koehler, health commissioner of Milwaukee.

Rev. Herman L. Fritschel, president of the association, who acted as chairman for all sessions, delivered his presidential address in which he outlined the progress made by hospitals during the past years and the present status of the institution in relation to the community that it serves. He emphasized his remarks with apt illustrations, from time to time, and his very interesting talk was thoroughly enjoyed by those present.

H. K. Thurston, executive secretary and treasurer of the association, read the minutes of the meeting held last year as well as the minutes of the Tri-State Association which was held at the same time.

The treasurer's report was not read but printed copies were distributed showing a balance of more than \$400 in the treasury.

### Describes Community Service Work

The first paper read was by Edward A. Fitzpatrick, director of the college of hospital administration, Marquette University, Milwaukee, and was entitled, "The Modern Hospital and Social Service." Dr. Fitzpatrick told of the many ways in which the hospital can serve the community and the best means by which the most may be accomplished. He compared the present day hospital with the hospitals of the sixteenth century and outlined the progress that has taken place.

Father Charles B. Moulinier, S.J., president, Catholic Hospital Association, in an impromptu speech told of the values of state meetings, and stated that it should be the aim of those present to work up interest in the meetings and to prevail upon superintendents to attend. He said that he had often found it difficult to get the busy Mothers General, Mothers Provincial and Mothers Superior to attend the Catholic convention, but that it was hoped that the importance of exchanging viewpoints would be made apparent to them within the very near future.

Matthew O. Foley, managing editor, *Hospital Management* read a paper "The Public Must Be Told," and this was discussed by John A. McNamara, managing editor, THE MODERN HOSPITAL, Father Moulinier, Miss Bena M. Henderson, Milwaukee Children's Hospital, and Rev. Fritschel.

Much interest was aroused by the round table questions, and the informal discussion that ensued brought out many excellent points. There were two sheets of questions numbering close to fifty topics. Miss Adda Eldredge, R.N.,

director of nursing education for the state of Wisconsin, was present at the meetings and intelligently discussed those questions that pertained to nursing and nurse education.

In the evening an illustrated lecture on x-ray valuations was given by Dr. James T. Case, surgeon, Battle Creek Sanitarium, Battle Creek, Mich. This comprehensive presentation was attended by not only the members of the association but also by many of the student nurses now receiving instruction at the hospitals in Milwaukee who were also interested listeners to the two following papers delivered by Miss Eldredge on the work accomplished by the committee on nursing education, and by Miss Ellen Stewart, R.N., superintendent, Theda Clark Memorial Hospital, Neenah, who spoke on, "The Patient —How to Provide for His Comfort While in the Hospital."

### Proper Charges for Laboratory Work

Wednesday morning's session was given over to two papers, more round table discussion and the announcements of the nominating committee. The first paper was by Dr. Edward L. Miloslavich, professor of pathology, Marquette University. It dealt with the proper charges that should be made for laboratory work. He advocated adequate charges for difficult analyses and showed how every laboratory could be put on a sound financial basis and at the same time do the most good for the patients.

Dr. John S. Coulter, Chicago, delivered a talk on physiotherapy in which he told of the many results that have been obtained by the uses of physiotherapy and other dependent therapies. He also urged the careful consideration of this branch of hospital work. His paper was discussed to some length by Dr. W. A. Henke, La Crosse.

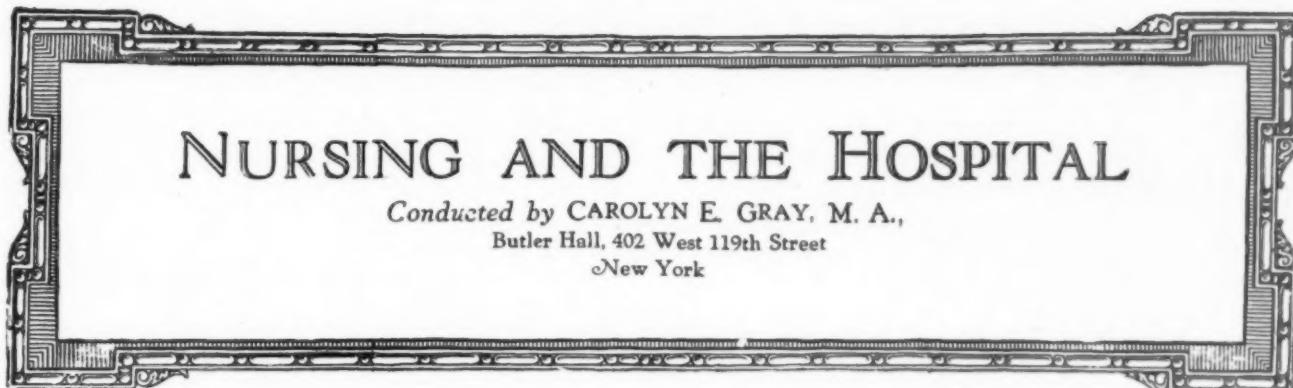
Dr. Henke, who was the chairman of the nominating committee, reported the following nominations:

President, Rev. Herman L. Fritschel, director, the Milwaukee Hospital; Dr. W. A. Henke, Henke Clinic, La Crosse, first vice-president; Miss Ellen Stewart, R. N., superintendent, Theda Clark Memorial Hospital, Neenah, second vice-president; Dr. R. C. Buerki, superintendent, State of Wisconsin General Hospital, Madison, trustee for five years; Miss Bena M. Henderson, superintendent, Milwaukee Children's Hospital and H. K. Thurston, assistant director of the Jackson Clinic, Madison, members of the committee on nursing education. The treasurer will be appointed by the board of trustees.

"Problems in Hospital Accounting" was the subject treated by Fayette H. Elwell, University of Wisconsin, and "Cost Calculation" was the title of the paper by Charles Karrow, superintendent, Columbia Hospital, Milwaukee delivered on Wednesday afternoon.

In the evening a banquet session was held at which time those present had the pleasure of hearing E. S. Gilmore, superintendent, Wesley Memorial, Chicago, and president the American Hospital Association for 1925. His address sparkled with humor and was tempered with common sense. The other speaker was Dr. Charles R. Bardeen, dean of the medical school, University of Wisconsin, who told of the work of the hospitals of Wisconsin.

Thursday's morning session completed the meeting. Three speakers were scheduled for this session. Prof. J. H. Kolb, department of agricultural economics, University of Wisconsin spoke on "The Service of the Hospital to the Small Community," Mr. S. Gazell of Milwaukee told of the operation of the hospital laundry and Senator Oscar H. Morris, Milwaukee spoke on hospital legislation.



## CHRISTMAS SPIRIT AT WALTER REED GENERAL HOSPITAL

By Theda E. Schulte, Second Lieutenant Army Nurse Corps,  
Washington, D. C.

**O**f all the charming days at Walter Reed Hospital the most delightful is Christmas. Plans and preparations begin long before the day arrives. One year five hundred tarlatan stockings were made after duty hours, then stuffed with candy, nuts, figs and dates, and name cards attached. What a neat array when finished! How attractive they looked piled high as Christmas drew near! There was a stocking for each nurse and student nurse,\* for each aid and student aid and for the student nurses affiliating in other places.

The surrounding country offers inexhaustible supplies of pine, ground pine and holly, and it requires but a day of work and pleasure to cut trees and greens and haul them to wards and quarters. At daybreak trucks start out and return heavily laden with fragrant pines.

The proudest, stateliest tree of all is placed on the green in front of the main building. Red, white and blue electric light bulbs are installed, and the community tree awaits the magic touch that gives it life. On Christmas Eve, at dusk, nurses and student nurses and aids gather about this tree and sing the age-old Christmas carols. As their clear, young voices ring out into the night, there comes a sudden flash, and the glory of the tree bursts like a flame of light. Every heart is stirred, and worships as "peace on earth, good will to men" floats on the breeze.

### Wards Become Fairy Bowers

On the wards deft, willing hands transform bare rooms into fairy bowers. Night nurses hang stockings at the foot of each bed to be found well filled when the patient awakes. A tree, adorned with tinsel ornaments, and glowing with lights, adds to the enchantment. Piney, woodsy fragrance pervades the atmosphere. Gratefully, patients turn to the tree glittering and shining with starry lights, sheltering gifts, and bringing messages of cheer from far away homes. All day long the hearts of the nurses are gladdened by the joy and sunshine that has come to weary sufferers.

At the nurses' recreation hut groups gather early. The tree in the center of the floor is alive with beauty. A radiant star at its tip glimmers and twinkles in the dim

light. Under the spreading branches lie heaps of bulging stockings, boxes of candy, baskets of fruit, and gifts for everyone—gifts from nurses to students, from "little sisters" to "big sisters." Growing plants, baskets of flowers and roses add to the charm of the occasion. An elusive fragrance is in the air.

When the distinguished guests, the Surgeon General of the United States Army and his staff, arrive, the lights turn on, and the tree stands out in all its splendor, dazzling, glittering. Fairy lights gleam from balcony and stairway, and over all hover good will and happiness. Then the fun commences and Santa, having much to do, calls upon his troops of fairies to help him distribute gifts. Dancing about the tree, songs and merrymaking follow, completing a joyous evening.

### Nurses' Quarters Attractively Decorated

This is but the beginning of a gay and festive time. Nurses and students make merry around their own tree and fireplaces in their scattered quarters. In each of the ten nurses' quarters there is a pretty tree, and attractive decorations. Stockings hang from shelf and mantle. Far into the night chatter and laughter ring out and mysterious secrets come to light. Few hours are wasted in sleep this glorious night.

At the Knights of Columbus chapel midnight Mass is held where many unite in worship.

Enthusiasm penetrates to the chief nurse's rooms. About midnight a magical change occurs, a tree takes shape with gold and tinsel trimmings, and colored balls and lights. Boxes and packages, large and small, find place beneath the tree. And then, in the soft glow of candles, enchantment holds sway. It is the spirit of Christmas.

On Christmas Day the festivities continue. The nurses' dining hall, with decorations of pine boughs, garlands and festoons, wreaths, sprigs of holly and mistletoe, is a picture of loveliness long to be remembered. The tables, with soft shaded barberry candles, are laden with delicious food. Santa presides at every table with gayety and mirth.

Several groups of lonesome student nurses in affiliation in other places far from their alma mater long for the happy Christmas days at Walter Reed. When the big

\*Member of the Army Nurse Corps and students of the Army School of Nursing.

boxes arrive bright with ribbons and holly, they shout with glee. Boxes are opened and turkey and other delicious foods appear. Notes tied with bright red yarn to Christmas stockings, bring messages of cheer, and dainty little gift packages reveal the thought of distant friends. Eagerly messages are read, expressions of remembrance reaching out from the heart of their school—the happy spirit of Walter Reed Hospital.

One of the most attractive and charming celebrations of the hospital is on the afternoon of Christmas Day at the large Red Cross hut when patients, assisted by the director of the Red Cross and her helpers, give a party. Their guests are the little children brought in from the families visited by the senior students taking a course in public health nursing in Washington. These children are the city's "Tiny Tims" who have known want and sadness. Here, in Santa's realm, patients with kindly hearts and loving hands share with them their abundant happiness.

Until the end of New Year's night the beneficent tree sheds its radiance like a benediction over all, and ever remains a lingering memory.

#### CAROLS THAT BRIGHTEN CHRISTMAS AT JOHNS HOPKINS HOSPITAL

By Dorothy M. Sutton, Class of 1926

Between midnight and dawn Christmas morning when all the ice-clad world without sparkles under myriad Christmas stars, there awakes within that spirit of contagious mirth that makes Christmas the most beloved of all the days. From a dozen flights of stairs gather the nurses of Johns Hopkins Hospital. A capped and caped procession forms in front of the evergreen that tips the ceiling of our entrance hall.

In this same hall, many years ago, the first Johns Hopkins carolers met and since then Christmas singing has become a tradition of our school.

Last year zest and finesse were added to the rehearsals by procuring from Peabody Conservatory of Music a leader whose skill brought unity out of numerous versions of time and tune. Were you ever distressed by the number of erratic improvised altos that a single hymn could acquire? These were humorously coralled and so moulded that they could march peaceably together. And many were the marches that, four by four, we made round pillar and post, through parlor and hall, so that the last of the procession's "Hark! the Herald Angels Sing, Glory to the Newborn King!" no longer sounded like a trailing echo to the voices of those marching ahead.

Such is the enthusiasm and freedom of these practices that they attract large numbers of the nurses. The routine excuse of being too busy is forgotten. Perhaps it is pride in the tradition of the place; perhaps it is the zeal and presence of the leaders of our school; or perhaps it is just the joy we humans find in singing the most beautiful of songs, the Christmas carols.

At all events on Christmas morning we are there—our superintendent, distinctive in black, her assistants and other members of her staff, in the envied white uniform intermingled with the undergraduate blue and pink, forming a bright regiment. From out our doors we go accompanied by the mascot of our carols, the little tuning pipe which, not being emotionally affected as are its human companions, calmly adheres to the correct pitch. Through the corridors we march to the lobby of the administration building. Under the balconied dome around the base of the great statue of Christ we group.

The Christ stands so silent, so calm, so strong. Inseparable from the figure is the message of hope and comfort carved beneath it, "Come unto me, all ye who are weary and heavy laden and I will give you rest." It is about this status of Christ, the Man, that each year we begin our songs of His nativity. With a thrill of joy our two hundred voices burst into:

"Joy to the world! the Lord is come:  
Let earth receive her King."

We carry the same glad spirit to the wards that are all garlanded with green and bright with sprays of holly. All of Christmas is there, even the bulging stockings hanging from the beds. A true Christmas welcome greets us from the eyes of our patients. Some beam with hopeful life; others look a bit wistful in their silent happiness. Down the entire length of the ward, the carolers sing. The patients, some feebly, some lustily, join in the familiar choruses. As we finish an old man asks, perhaps, for a favorite hymn. Singing it we leave the ward, accompanied sometimes by a burst of "Merry Christmas," sometimes by silence.

It is on M and O, our wards for colored patients, that we receive the frankest response. From beneath red blankets, broad grins show that among the throng a favorite "Miss Nurse" has been recognized. With a child-like pride of possession, they glory in the admiration of their tinselled tree and scarlet bells. As we begin to sing their mellow voices swing with religious zeal into the rhythm of "O Little Town of Bethlehem." A hushed fervor comes over them as they enter into the most sacred of the season's hymns "Silent Night." It is as they are singing this that the carolers move quietly beyond the outer doors. Most beautiful of all this music comes back from the starlit bridges. As it dies out, far away and unseen, it is indeed as if it were descended from some heavenly host as were the first alleluias.

To each of us "Silent Night" more than any other hymn, brings the memory of the little group with which other Christmases have been spent. As we sing it there comes heartache and a longing to be at home. Then comes a gladness, too, that we are here in a new home, in a new and interesting world, a part of a great work. Leaving a warmth of Christmas feeling spread over our sick we come again ere day has begun to the doors of our nurses' home. Carols are over; yet not over, for the memory of them ever remains one of the most memorable parts of our training.

#### WHAT THE FUTURE HOLDS FOR THE REGISTERED NURSE

Nursing is one of the most useful and satisfying professions which any woman can enter.

The most inspiring part of the work is the privilege of assisting in the wonderful results which are being accomplished by physicians and surgeons, and other leaders in the field of research and practical medicine. The nurse's work is an essential part of all these activities; and so she has a vital interest in every detail connected with them.

As superintendent of a hospital, or a school of nursing, as head nurse in hospital wards or operating rooms, as supervisor of dispensaries and clinics, there are always opportunities for rapid advancement.

As a nurse instructor in schools of nursing and as an instructor in Red Cross courses in home care of the sick, the demand far exceeds the supply.

As visiting, school, child-welfare, medical, social service and industrial nurse, there are unlimited opportunities.

THE use of coffee, cocoa and tea is so general that a dogmatic statement is antagonistic to many persons, and the views concerning the effects of such use so conflicting that a final statement at this time is impossible. It is probably always true that whenever statements vary widely the truth lies at some intermediate point. As regards coffee, it is unquestionably true that to some persons coffee is a poison, causing toxic eye conditions, disordered digestion, and *nervous disturbances*. On the other hand, some persons drink it without any deleterious effects that are noticeable. The same may be said for tea and cocoa. It is unwise to say that coffee or tea will harm no one. It is foolish to condemn for all.

*From the writings of Prof. Jesse F. Williams*



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When using advertisements see Classified Index, also refer to YEAR BOOK.

## FRENCH NURSES STUDY OUR METHODS

**A**SOMEWHAT unique American postgraduate study has just been completed by two graduates of the Rue Amyot School of Nursing in Paris.

Mlle. Madeline Drancourt and Mlle. Marie Moreilhon finished their course in this school, of which Mlle. Jeanne de Joannis is the directress, in the fall of 1924. After successfully passing the state examinations for registration at the first examination given by the French Republic they were sent by the courtesy of the American Committee for Devastated France to the Woman's Hospital of Philadelphia. The directress of nurses in this hospital, Miss C. K. Swank, was a friend of Mlle. de Joannis when they were taking a course at Teachers' College, Columbia University, New York, and there was also an official connection with the Woman's Hospital, a Frenchwoman, Mrs. Emelie Lehman, the business manager, who was particularly interested in these two young women because during the war she herself had been associated with the American Committee for Devastated France. So it was under these particularly happy auspices that arrangements were made for the French nurses.

They were met at the dock by Mrs. Lehman who from the moment of their arrival took these young country women of hers under her wing and into her heart. Through the courtesy of the board of managers of the Woman's Hospital it had been agreed that the two nurses should be allowed to live in the nurses' home of the hospital, while pursuing a four months' course in public health nursing that they were to take under the Visiting Nurse Society of Philadelphia. This was a generous offer as the young women were contributing nothing to the hospital during these four months. As a result they have had a home in America from the first day of their arrival and will always feel toward the Woman's Hospital as though they belong to part of the fortunate family there.

As these French nurses were destined to return to Paris to assist in the Rue Amyot School their work was planned with this in view. In the Woman's Hospital they had four months' experience and instruction in obstetrical nursing. They assisted in more than twenty-five deliveries, some of which were very complicated cases. They had experience in the wards, in the nursery and in the milk room and were under the daily supervision of the teaching staff of the hospital.

### Four Months' Public Health Nursing

Their four months' public health nursing under the direction of Miss Tucker of the Visiting Nurse Society was of great value and interest to them. This included experience in visiting nursing, maternity care, prenatal and postnatal care, communicable disease, and general family health supervision. One month of this time was spent at the Phipps Institute for the study of treatment and prevention of tuberculosis where they had experience in the tuberculosis clinic and prenatal and well baby clinic, together with the follow-up work in the home with special emphasis placed upon medical social service. During the visiting nursing course they attended thirty-eight hours of class instruction including demonstrations and case conferences.

The financial arrangements that were made with regard to these students seem to have been very satisfactory. The American Committee for Devastated France which had arranged for their transportation to this country gave them an allowance of \$40 per month. The Woman's Hospital provided them with full maintenance but no

salary during the postgraduate work of three months or during the four months that they were guests of the hospital although pursuing their studies with the Visiting Nurse Society. For one month while they were at the Woman's Hospital they were on general duty in the obstetrical department. This was at the end of their stay in this country when they were able to render full service to the hospital. For this period they were paid by the hospital at the usual rate. During this month they did not accept the allowance from the American committee. It is interesting to note that they were able to meet all their expenses, to have many incidental pleasures and small excursions and also to save a considerable sum.

Upon their return to Paris one of these nurses is to assist the instructor of nurses at the Rue Amyot School of Nursing in her supervision of the practical work of the students in the hospital wards, and the other is to direct and supervise the visiting nurse work that is done by the students of the school in the crowded area in which the school is situated.

### Visited Army School of Nursing

The students' trip did not include extended sight-seeing or visiting of many institutions. They were shown many interesting things in and around Philadelphia. They also spent a week-end in Washington where they visited the Army School of Nursing and they passed three days in New York City before sailing. It was felt that in the case of these young women time and money should be concentrated upon very definite things rather than spread over an accumulation of sights and unrelated facts, however interesting, but possibly of little practical use except as a background of general information. Both young women have shown themselves adaptable, intelligent and able to obtain the most from their opportunity. The fact that they speak English well was one of the reasons they were chosen for the study trip.

The success of this plan will of course only be proved by the results to be seen in later years in the contribution these women will make to the nursing profession through the work they are to undertake in Paris.

The French nurses and school of nursing in Paris from which they came are not the only groups who have benefited by this study course. It is felt in the Woman's Hospital, not only by the board of managers and the faculty of the school, but by the students, that the French women have made a large contribution to the life of that institution and have broadened the horizon and increased the feeling of Franco-American professional understanding and friendliness in a way that nothing else could have accomplished. The arrangement has been of great mutual benefit and it is hoped that it can be repeated in the very near future.

### RECEIVES 1925 SCHOLARSHIP

Virginia Eberman, a graduate of St. Mary's Hospital training school, Rochester, Minn., has been awarded the \$200 scholarship offered by *The Trained Nurse and Hospital Review* for the year 1925, for the best thesis on a phase of nursing.

"The Nurse in Poetry" is the theme of the 1926 Calendar published by the National League of Nursing Education. It contains a collection of verses, and twelve pages of illustrations of unusual originality feature the months.

# Hospital Association Convention

## LOUISVILLE, KY.

October 23rd, 1925

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Palmolive helps physicians and nurses keep their hands smooth and comfortable. So of course, they're much interested in Petit Palmolive, our new individual cake, in the standard wrapper. It's in demand both for use of staff and for private room patients. Such endorsement is highly gratifying and it's the basis of orders which are more gratifying still. Am leaving with that happy feeling that a very pleasant time has been had by all. Fuller report on return. Faithfully yours.

The Palmolive Representative

### To Hospital Managers:

The Palmolive line is made up of soap specialties headed by famous Palmolive. Each gives just a little better value at a decidedly lower price than competition offers. At least, that's what users say.

The Palmolive price list should be on the desk of every hospital manager, ready for reference when soap for any purpose whatsoever is needed. If you haven't the latest edition of this list write and one will come by return mail.

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## DIETETICS AND INSTITUTIONAL FOOD SERVICE

*Conducted by LULU G. GRAVES, 7 East 54th Street, New York  
and MARY A. FOLEY, Director of Dietetics, Kahler Hospital, Rochester, Minn.*

### HOW THE DIETITIAN SPREADS CHRISTMAS CHEER

*Christmas at Clifton Springs Sanitarium and Clinic, Clifton Springs, N. Y.,  
By Helen Clarke, M.S.*

THE Christmas Day celebration with its varying demands gives the hospital dietitian an incentive to spend a busy, happy day in the service of others. In the decoration of dining rooms and in devising new ways to give the food service a festive air she has unlimited possibilities.

In our institution a holiday menu is provided, offering a greater variety of foods and some extra dishes whose chief appeal is that they are not frequently served.

The breakfast trays of the patients carry a holiday greeting card from the sanitarium but at noon is the real celebration. The patients who are not restricted may order from the printed menu at the table or for tray service in their rooms. For many the real privilege of the day is to go to the dining room for dinner. Those who are receiving special weighed and computed diets have a modification of the more elaborate menu.

From a menu like the following it is possible to make an adaptation for every type of special diet. The cocktail is used for almost everyone and the soup by the majority of the patients. For those who require strained food the same vegetables may be used. Different types

of ice cream are served and those made from thin cream with saccharin are suitable for many patients.

The following is the type of menu suitable for special diet patients:

Grapefruit Cocktail	Cream Soup
	Dinner Rolls
Roast Chicken or Roast Goose	Mashed or Baked Potatoes
Hubbard Squash	Fresh Spinach
Fruit Salad, Whipped Cream	Fruit
Ice Cream	Coffee
	Tea

As diabetic patients are often more restricted than others their menu shows the following modification from the general one:

Fruit Cocktail
Roast Goose and Cranberry Sauce
Celery and Radishes
Green Peas
Lettuce Salad with Mineral Oil Mayonnaise
Ice Cream

The decoration of trays varies from one year to another but usually favors are used. Nut cups or strips of crepe paper add color and often individual place cards are used. One of the most popular decorations is diminutive trees with cotton and artificial snow. Gluing the base of the trees to small cards gives a foundation.

In the main dining room large, flat, paper bells on the wall spell out "Merry Christmas". On the tables are potted



A sample Christmas tray at Clifton Springs Sanitarium.

6 December, 1925

THE MODERN HOSPITAL

Adv. 49

J

L

AMERICA'S MOST FAMOUS DESSERT  
**JELL-O**  
A MIXTURE  
NET WEIGHT 20 OZS.  
MAKES FOUR QUARTS  
**STRAWBERRY**  
PURE FRUIT FLAVOR  
VEGETABLE COLOR  
This package makes four quarts of  
Jell-O. Serves forty to fifty persons  
according to size of portion.

Divide the package into four equal parts and add one part to two quarts of boiling water. After it has been dissolved, add two quarts of cold water. Allow to stand for one-half hour. Then add one part of boiling water for each quart of Jell-O. The water must be very hot.

Keep the directions of your physician or dietitian. The Jell-O Company, Inc., 100 Broadway, New York.

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America's most famous dessert

plants such as Jerusalem cherries. Wax poinsettias banked on the mantelpieces against the mirrors are effective and with large wreaths a real holiday atmosphere is produced.

The nurses' dining room is lighted with candles for breakfast. Evergreen is used for decoration and often small trees are placed on the tables.

In the afternoon the superintendent of nurses, remembering her first lonely Christmas in the training school, always gives a tea. Students and graduates gather and enjoy chatting over their holiday experiences while refreshments are informally served.

#### *Christmas at Dr. D. W. Groves L. D. S. Hospital, Salt Lake City, Utah.*

Here as elsewhere the days previous to Christmas are filled with the spirit of good-natured mysteriousness and promise.

From the bakeshop comes the promise of fruit cake and other seasonal dainties while the student nurses are busy planning surprises for the Christmas tree.

The night before Christmas the Christmas party is given. It consists of an entertainment, in which even the dietitian forgets her dignity and dresses the part of a comedy character. The program is given by the student nurses and all native talent is brought into play. The comedy relieves the homesick atmosphere of the girls who are spending their first Christmas away from home.

After the entertainment, which is held in the school room, everyone goes to the living room where a member of the staff plays Santa Claus. Through the kindness of one doctor the nurses always have a big Christmas tree, and all the packages received by mail are then given out by Santa Claus, who keeps the crowd amused with personal observations.

Several days before Christmas, the names of the girls and of the supervisors are exchanged and each one puts a present on the tree that does not exceed fifty cents in value. In this way no one is left out. Through the contributions of the doctors, each girl is provided with a stocking of candy, nuts and fruit. The stockings are filled by the supervisors the night before. Each child who is in the hospital at Christmas time receives one of these stockings.

After the distribution of presents the nurses sing Christmas carols and the party is over.

On Christmas Day all day nurses and supervisors assemble for breakfast by candle-light, an individual candle being placed on each service plate. The tables are prettily decorated and a special breakfast is served.

After breakfast the student nurses proceed to the hospital where three Christmas carols are sung for the patients.

The patients have a candle-light breakfast too, as an individual candle is placed on each tray and just before it is taken into the room the candle is lighted.

The hospital sends a card of greeting to each patient, and every employee receives a card of greeting.

The main entrance hall of the hospital has a Christmas tree which is lighted with colored electric lamps, and all the corridors are hung with wreaths of holly and Christmas bells.

The children's rooms always receive extra trimming and trees.

Not least important is the Christmas dinner that every patient who is well enough receives. It consists of turkey with all its trimming, candy served in gay baskets, nuts and raisins, cranberry sauce and plum pudding. Even the patients who are on a soft diet have their ice cream

or custard brightened by a bit of red cherry.

In the diet kitchen we substitute diabetic candy for the diabetics; for the children agar dolls of green and red. Last Christmas one diabetic boy of fifteen carried his "bran gingerbread boy" all the way home to show his parents on Christmas afternoon.

For dessert for the diabetics we make a pumpkin pie which most patients like very much.

#### *Pumpkin Pie*

The filling: Canned Pumpkin, 50q.

Egg Yolk, 1.

Cream, 40 q. (20%).

Saccharine,  $\frac{1}{4}$  grain.

Small amount of cinnamon.

Cloves and nutmeg.

Use 25 q. of cream to mix with egg yolk and pumpkin, and save the rest and whip for top of pie.

The crust: Lister's flour, 5 grams.

Egg, 10 grams.

Butter, 5 grams.

Water to moisten.

Add Celluloflour to make crust large enough to line an individual pie dish.

Total food value: protein, 9; fat, 19; cho., 5.5.

For the nephritis we make simple candies, and serve them a carrot pudding which is a good substitute for the rich plum pudding.

Thus we try to cheer those who must spend their holidays in a hospital, and strive to make them feel that though they are deprived of some of the season's cheer there is much to make life worth while.

#### *Christmas at University of Michigan Hospital, Ann Arbor, Mich.*

*By Mary Harrington*

Christmas, the season of feasting for all, is often a time of sadness, envy and longing for the diabetic.

In the days when the methods of treating this disease were fasting and low-calorie diets, how disappointing it must have been for the diabetic patient to see the festive house tray brought to his neighbor in the next bed, and to receive for his own allotment of the Christmas dinner only a few vegetables! For him this reason served mainly to emphasize his misfortune, and sometimes temptation was stronger than his will power.

Now, however, the diabetic patient receives his tray with many of the same foods as his neighbor and the fact that the quantities are smaller does not disturb him greatly. Oftentimes, the diabetic tray can be made more attractive than the house tray because it has more color; then the other patient is the envious one.

No. IV. Diet.	Protein	Fat	Carbohydrate	Calories
Vegetables 5%.....	53.8	210.5	34.8	2240
Vegetables 10%.....	100 gms.			
Vegetables 15%.....	40 gms.			
Cream 40%.....	150 gms.			
Butter .....	40 gms.			
Bacon .....	40 gms.			
Eggs—3 .....				
Mayonnaise .....	60 gms.			
Lamb Chops .....	100 gms.			

No. IV. Diet with substitutes	Protein	Fat	Carbohydrate	Calories
Vegetables 5%.....	400 gms.			
Vegetables 10%.....	100 gms.			
Vegetables 15%.....	40 gms.			
Cream 40%.....	45 gms.			
Butter .....	45 gms.			
Bacon .....	40 gms.			
Eggs, 1 .....				
Roast Turkey .....	40 gms. (Cooked weight—substituted for 2 eggs)			
Mayonnaise .....	60 gms.			
Walnuts .....	5 gms.			
Roast Turkey .....	60 gms. (Cooked weight—substituted for 100 gms. lamb raw weight)			

10 grams of cocoa butter candy contains: protein, 0.2 gms.; fat, 9.3 gms.; carbohydrate, 0.5 gms. This may be substituted for 10 gms. of butter in the diet.



Sisters Hospital, Sacramento, Calif. Crane Materials Used Exclusively. Architect, R. A. Herold, Sacramento; General Contractor, W. E. Keating; Plumbing and Heating, J. H. Cummins; Consulting Engineers, Hunter and Hudson, San Francisco

### DEPENDABLE EQUIPMENT IS VITAL IN THE HOSPITAL

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and heating materials are so frequently chosen by local authorities and national architects. Their selections are cumulative evidence of the economy, efficiency and dependability of Crane equipment. They suggest, too, Crane understanding of hospital requirements as well as Crane experience and knowledge. You can benefit from this. Let Crane engineers aid you in planning your new hospital.

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in Sisters Hospital, Sacramento*

The following menus are planned for a bare maintenance diet consisting of 55 gms. of protein, 210 gms. of fat, and 35 gms. of carbohydrate, with a total of 2250 calories. It is a simple matter to increase the quantities for a higher diet, or to balance the arrangement of available glucose for an insulin case.

## MENU

## I

<b>Breakfast</b>	Grapefruit—50 (Serve in half-shell with garnish with a cube of mint agar) Bacon—40 Eggs—1 (Omelet) Cream—20
<b>Dinner</b>	Clear Bouillon. Roast Turkey—50 gms. plus melted butter 15 gms. Parsley 5 gms. Head Lettuce—50 gms. plus 1,000 Island Dressing: Pimento .... 10 gms. Green Peppers 5 gms. Sour Pickles... 10 gms.
	Celery—20 gms. Cranberry Sauce: Cranberries .. 50 gms. Agar Jelly... 2 Tbsp. Saccharin .... 1/4 gr.
	Strawberries ... 60 gms. Whipped cream.. 70 gms. Walnuts ..... 5 gms. Cocoa Butter Candy—10 gms.
<b>Supper</b>	Cold Turkey—40 gms. Lettuce —10 gms. Tomatoes 90 gms. plus Mayonnaise—30 gms. Brussels Sprouts—100 gms. plus Butter 20 gms. Diced Pineapple 50 gms. } plus Whipped Cream—30 gms. Mint Agar Cream (for coffee)—20 gms. Cocoa Butter Candy—10 gms.
Protein, 53.9; Fat, 210.0; Carbohydrate, 35.3; Calories, 2,251.	

## MENU

## II

<b>Breakfast</b>	Apples—40 gms. Color, Red Sweeten with 1/4 gr. saccharin Bacon—40 gms. Eggs—1 plus egg whites 1 Cream—20 gms.
<b>Dinner</b>	Roast Chicken—67 gms. Celery—20 gms. Lettuce Radishes } 80 gms. plus Mayonnaise—30 gms. Cucumbers Pumpkin Custard Pumpkin—100 gms. Egg yolks—1 Cream—20 gms. Plus Whipped Cream—60 gms. Red Agar in cubes
<b>Supper</b>	"Pigs In Blankets" Oysters .. 100 gms. Bacon ... 50 gms. plus butter 10 gms. Diced Endive Celery Tomatoes 100 gms. plus Mayonnaise 30 gms. Pickled Beets—50 gms. Diced Grapefruit and Strawberries Mint Agar Cocoa Cream (40%)—55 gms. Cocoa Shells Extract—150 gms. Saccharin—1/4 gr.
Protein, 54.7. Fat, 210.5 Carbohydrate, 34.2. Total calories, 2,250.	

## Recipes

<b>Agar.</b>	5 gms. Agar. 1 qt. boiling water. 1/4 gr. saccharin. 1 tbsp. of green or red fruit coloring. Boil agar in water until thoroughly dissolved (about 10-15 minutes.) Add saccharin dissolved in flavoring. Color and chill. 1 tsp. of mint flavoring or 1 tsp. of vanilla may be used. This agar jelly makes a satisfactory jelly basis for cranberry sauce or fruit jello; a small amount adds to the consistency of a mousse.
<b>Cocoa-Butter Candy.</b>	Cocoa-butter—58 gms. Bitter chocolate—5 gms. 1/4 gr. saccharin. 5 drops vanilla. Soften coco-butter and chocolate over boiling water. Add 1/4 gr. of saccharin, dissolved in vanilla. Chill, and cut into squares. This recipe makes about 60 gms. Ten gms. contains protein, 0.2 gms.; fat, 9.3 gms.; carbohydrate, 0.5 gms.
<i>*These recipes by the courtesy of Dorothy M. Stewart.</i>	

Christmas at Rockford Hospital, Rockford, Ill.,  
By Naomi Waffle

Christmas trays present a big problem. It is at Christmas time that we all wish to be at home. For those of us who are well, it is sometimes trying enough to think of the folks at home around the Christmas tree and the dinner table, but for the patient it is far worse. It is the dietitian's problem to cheer the patients and make them forget their troubles for a while if possible.

The breakfast tray starts the day. We have cardboard bases covered with red and green crepe paper holding red candles; an apple makes an attractive base for a candle. These candles are lighted as the tray is carried into the room of the patient. A sprig of holly placed on the napkins gives a bright spot of color to the tray. Grapefruit baskets with cherries always make an attractive first course for a Christmas breakfast.

Most important of all is the dinner tray. Of course the menu is as important as the decorations of the tray. It must be simple but sufficient. For the first course there may be choice of soup or oysters on the half shell with the oyster sauce. Next, perhaps, roast turkey with dressing, mashed potatoes and sweet potatoes, a vegetable or a salad and the dessert. For those on the lighter diets, I serve ice creams and cakes; for the others mince pie. The decorations for the trays are usually made by the nurses in the diet kitchen at the time, or we have parties to make them. The girls enjoy making the nut baskets, place cards, and the other things. We always have nut baskets filled with salted nuts, candies, and raisins. We buy the plain white cups and decorate them with red and green paper, and wire wound with paper for the handles. Using the place card with its holly or an appropriate Christmas scene painted on it makes the patient feel the individual interest we take in our patients. One year we made little gumdrop bouquets of red and green gumdrops, with a lace doily and red and green maline background for them. We covered the wire stems with green paper and tied them with red ribbon. These were especially popular. Individual Christmas trees are very popular but are more expensive than the other suggestions.

## CALIFORNIA DIETITIANS ORGANIZE

The California State Dietetic Association was organized at a meeting of the dietitians of the state held at Fresno, November 1. The following officers were elected for the coming year: president, Helen B. Anderson, Methodist Hospital, Los Angeles; first vice-president, Elvian Misch, University Hospital, San Francisco; second vice-president and educational chairman, Ruth H. Bowden, Cottage Hospital, Santa Barbara; secretary, Martha E. Davis, Scripps Metabolic Clinic, La Jolla; treasurer, Mrs. Rae Snow Schneider, Alameda County Hospital, San Leandro.

The purpose of this organization as set forth in the constitution is to maintain high standards of education and efficiency for hospital dietitians and other professional women engaged in the prevention and care of disease by dietary measures; to promote the welfare of student dietitians by providing prospective students with unbiased and impersonal information concerning "schools for student dietitians" and to promote the welfare of said schools by providing information to hospitals as to the proper organization and standards for such schools; and to serve physicians, hospitals and other institutions whose purposes are in harmony with this organization by providing reports on such phases of the general problem of foods, service and dietotherapy as are of value.

# Why Pyrono Doors and Trim Are So Useful

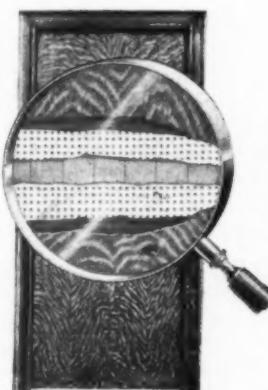
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## OUT-PATIENT SERVICE

*Conducted by MICHAEL M. DAVIS, Ph.D., Executive Secretary, Committee on Dispensary Development, United Hospital Fund of New York, 15 W. 43rd Street, New York  
and by ALEC N. THOMSON, M.D., Medical Secretary, Committee on Dispensary Development, United Hospital Fund of New York 15 W. 43rd Street, New York*

### THE RECEIPT FORM FOR ADMISSION FEES

#### Uses for a Receipt Issued to the Out-Patient Upon Payment of An Admission Fee

By the Records Committee of the Administrative Section of the Associated Out-Patient Clinics of New York.\*

**S**UBSEQUENT to the publication of the report of the committee on records of the administration section of the Associated Out-Patient Clinics in 1924, the committee made a study of the forms used in several outpatient departments to indicate that the patient has paid his admission fee. A receipt form, while not considered by the committee to be a minimum requirement in outpatient administration, was deemed advisable for every clinic whatever its size, since it may serve a number of purposes. The outstanding uses were considered to be as follows:

(1) To indicate to the clinic that the patient has been admitted in accordance with the proper routine concerning payment.

(2) To refund to the patient his money, or to give credit for it, in case he does not for any reason receive treatment.

(3) To furnish the patient with legal proof of payment.

(4) To check up on income from patients.

Of the items found on the receipt forms analysed the three following were considered essential: Name of institution; amount paid, and receipt serial number.

In most cases the date is also essential. This is an aid in checking and saves much of the refunding. If a patient gets no treatment on a certain day, instead of getting his money back he keeps his receipt which the cashier stamps with the date of the next visit.

The following are the items found on the receipt forms examined: Name of institution; address of institution; department designated—by name, by color of card, by both name and color; room number; signature of registrar; name of physician; date; amount; sex; sequence number; history number; "Good for today only;" "To be returned by physician;" "Patient must give this ticket to druggist together with prescription slip;" temperature, pulse, respiration, weight (on back).

In addition to the four outstanding uses for the receipt form listed in the beginning of this article, there are other purposes for which the receipt form might be used, depending on the particular system of admission. The

form should be adjusted according to special requirements. Some of the purposes suggested were:

(1) To guide the patient. These slips may be colored according to clinic; this is not possible with the cash register, though a symbol can be printed to indicate the clinic. Some designation of clinic is valuable for a check-up on returned histories after clinic sessions. In any event the patient carries his admission card and this bears the name of the clinic or clinics which he attends.

(2) To carry the patient's sequence number for the particular clinic for the day; this also furnishes a means of gathering statistics, the number of visits being ascertained by a comparison of the first and last numbers issued for each clinic.

If patients visit the clinic strictly by appointment, no sequence number is needed for the purpose of admitting them according to order of arrival. The sequence number is usual, however, where no appointment system is maintained. If a cash register is used this number will have to be written on separate slips used for the purpose.

Gathering statistics by noting the number of tickets given out for each clinic is not an absolutely accurate method since some patients do not remain for treatment and do not go back to the cashier for a refund. If the receipts collected in the clinics are used for gathering statistics, the error is apt to be in the opposite direction; patients fail to leave them or they get lost, making the statistical count too low. The accurate method is to count visits directly from the histories; thus (in the central filing system) one person is responsible instead of as many persons as there are clinics. If any histories come back with no note of a visit, a check-up can be made immediately to ascertain whether or not the patient was treated. This method also insures some note being made by the physician of every visit to his clinic.

(3) To indicate to the historian what histories are desired by showing on the stub the patient's history number. This point will be touched upon in discussing the cash register.

(4) To bear on the reverse side temperature, blood pressure, respiration and weight, these to be entered when desired, by a clinic assistant before the patient sees

\*Committee: E. M. Bluestone, M.D., chairman, Mark L. Fleming, M.D., Joseph D. Flick, Frederick MacCurdy, M.D., James U. Norris.

December, 1925

THE MODERN HOSPITAL

Adv. 55



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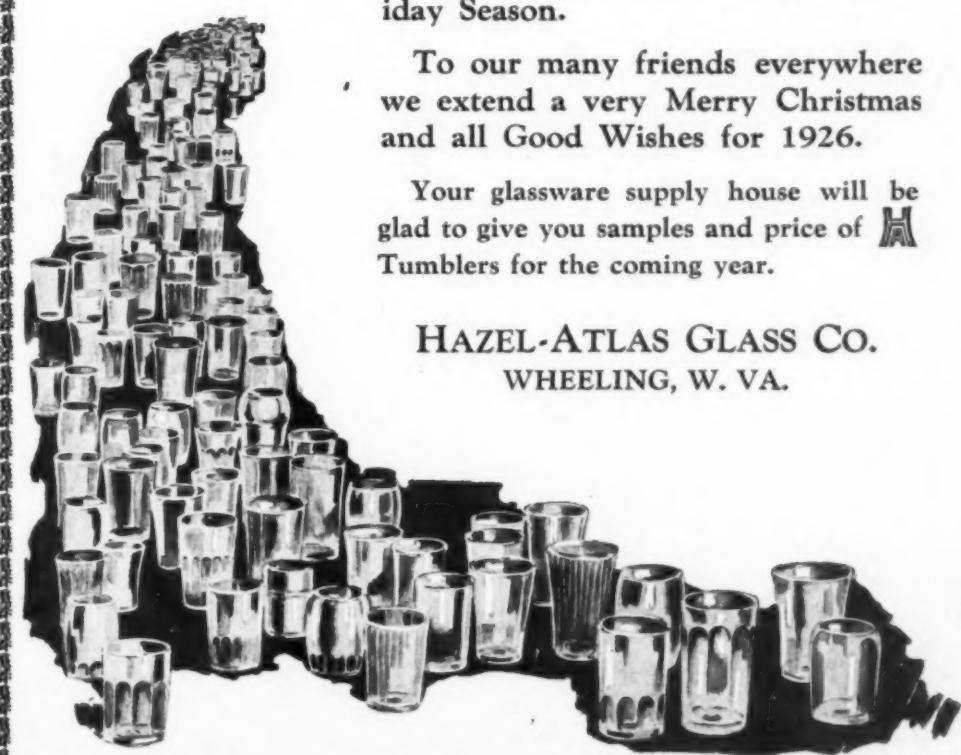
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the physician who is to be in charge of the case.

(5) To be used for special research, such as the study of the waiting time of the patient. The time the form is issued and the time the patient goes in to the physician can be noted for such special study.

(6) To print health ideas on the reverse side from time to time.

The receipts should always be collected in the clinic. If the receipt is immediately put upon a spindle or in some such way punched (or put into a locked box provided with a slit in the cover), it will prohibit its use a second time; that is, if a patient picks up a receipt form in the clinic and endeavors to use it for another visit, the hole punched in the slip will indicate this.

The printed receipt form is preferable, as this does away with writing and also furnishes a check-up on the cash taken in. The printed form requires either a cash register or an automatic ticket seller. With the former, keys are punched to print, in duplicate, the desired in-

formation on the receipt, one part being given the patient, the other retained by the cashier, or, in some cases, where the patient's history number is printed, it is sent to the history room to inform that department what histories are wanted. On this same cash register receipt the clinic desired can be indicated by symbol, letter or figure; this provides the historian with the information necessary in routing the record properly.

With the automatic ticket seller the receipts are printed in advance, inserted in the machine in rolls, and issued to the patient by pressing a button. As many rolls and as many buttons are necessary as there are different fees except where one fee is a multiple of another, in which case two receipts may be issued. This type of machine cannot print the history number or the date; nor can it indicate the clinics without complicating the process by adding a roll for each separate clinic. Statistics may be gathered by comparing the first and last numbers for the day.

## SUPERVISING OUT-PATIENT HISTORIES BY MEANS OF A CHECK-UP FORM

### A Suggestion for Checking the Contents of the History to Insure a Complete Medical Record

By A Committee of the Associated Out-Patient Clinics of New York.\*

THE main difference in keeping ward and out-patient department records lies in the fact that ward histories are completed on the discharge of the patient from the hospital, whereas out-patient department records are, as a rule, difficult to complete because the patient is not similarly controlled. For this reason it is necessary to check the out-patient department record after each visit the patient makes to insure completeness.

The importance of this check-up was recognized by the administrators and clinicians, members of the administration section and of the medical section of the Associated Out-Patient Clinics, in their discussion of principles underlying good records and good record keeping. They stressed the necessity for supervision of records. Who should supervise them? Who can? There is a diversity of opinion on this point and the responsibility for supervision has not always been definitely placed. The chief of clinic, because of his position, is responsible for every kind of medical service that is given to the patient in his clinic. Since the clinical record is considered an integral part of medical service, it is reasonable to assign to the chief of clinic the ultimate responsibility for these records. He should be encouraged to consider the proper filling out of the record quite as important as accurate diagnosis or complete treatment.

While there is general agreement with the principle, it is not possible in actual practice for the chief of clinic to review every medical record at the conclusion of each session. In a heavy clinic with a large number of patients he would be overwhelmed even if this were his only task. The effort in defining these principles is in the direction of an ideal clinic where the number of patients seen by a physician is limited to a group that could be given well-rounded service (which includes rec-

ords) and where some of the responsibility for supervision could be delegated to assistants.

To this end, the chief of clinic should assume responsibility for the recording of clinical facts as part of the general scheme of medical supervision. This does not imply that he must see every record personally, but it does mean that his subordinates should be so instructed in adequate record keeping that the chief of clinic need be called in only on those cases which require his more mature opinion. Since he is to be held responsible for the supervision of the records written by his assistants, the record room clerk should present incomplete records to him in order to enable him to review those records with the physicians in his clinic. Records may be checked for omissions by means of the "check-up form" that has been devised for that purpose.

#### Check-Up Form for Histories

A sample form should be given to the record room clerk to guide her in auditing records. It should include the basic items necessary in a good record. The administrative items are already printed on the record and need not be repeated on the check-up form except as a group. These are: (1) Name of out-patient department; (2) name of patient; (3) history number; (4) address; (5) date of admission; (6) clinic; (7) sex; (8) civil status; (9) age; (10) exact occupation. If one or more of these is omitted the clerk can easily discover what is missing and check "Administrative Items" on the form.

The medical items could be printed on a 3x5 inch card or paper to be attached to the record by the clerk if the physician had omitted any of those checked. When the patient returned and the card was again before the physician, his attention would be called to his oversight by the attached slip. The time spent in checking would be reduced as the clerk became more familiar with the items on the form.

\*Committee: E. M. Bluestone, M.D., Chairman, Mark L. Fleming, M.D., Joseph D. Flick, Peter Irving, M.D., Frederick MacCurdy, M.D., Luther MacKenzie, M.D., James U. Norris.

# Vases, pails, waste-baskets made by an amazing new process in one solid seamless piece..... noiseless, rustless, waterproof

FROM the dawn of history, man has sought a satisfactory means of holding water and other liquids. But always containers have had defects.

Clay pots broke. Earthenware absorbed its contents. Wood broke or became foul. Metal rusted—the cheaper the quicker.

Now, after countless centuries, modern science has produced the ideal container. It is called Cordleyware.

This Cordleyware is not only waterproof—it is noiseless; rustless; taint and odor proof; a non-conductor of heat and cold; scratchless and non-scratching; and practically indestructible.

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type of container on the market, although it has qualities no others can possess.

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The new Cordleyware waste basket—noiseless, rustless—waterproof—non-corrodible; colors, mahogany, foliage green or to order in 12 doz. lots—rustic or leather finish. 3 sizes.



Cordleyware spittoon, waterproof—rustless—noiseless—sanitary—taint and odor proof, cleans instantly in hot water. Tops of steel, white or mahogany to match body.

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Cordleyware products also include waste baskets, spittoons, pails, fire pails, etc. Write for prices.



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In some institutions a penciled note, indicating omissions, is attached to the record which is put in a rack where the physician knows it is placed for correction.

The objections that it is undesirable to multiply forms and that a clerk might not be competent to pass on a clinical record, are overbalanced by the fact that time would be saved, the value of the record would be emphasized and the records would be complete both as to administrative items and medical content, thus increasing their value.

#### Promoting Continuous Treatment

It is desirable for the physician or his clerical assistant to note on the record the date when the patient should return. Such notation is necessary to permit adequate follow-up service, to indicate in writing that the patient has been informed of his return date, and to give information to any one else interested in the case (physician, social worker or nurse). This is considered a good index of the cooperativeness of the patient (and physician).

When this check-up form is printed, it is helpful if the items that relate to new records only are printed in bold-faced type, as in the following list, to distinguish them from those that pertain to both new and old cases. This differentiation of the type will aid the clerk with repeated use of the form to check up almost automatically.

The following items are necessary:

- (1.) **Administrative items (see above).**
- (2.) **Chief complaint and duration.**
- (3.) **Family history.**
- (4.) **Past history (including reports of treatment at other clinical agencies).**
- (5.) **Present history.**
- (6.) **Physical examination.**
- (7.) **Diagnoses.**
- (8.) Requests for and reports on laboratory examinations.
- (9.) Requests for and reports on social history notes.
- (10.) **Summary (desirable).**
- (11.) **Treatment.**
- (12.) Requests for and reports on consultations (diagnosis or treatment).
- (13.) Signatures of persons responsible for clinical, social, and laboratory entries with dates.
- (14.) Date patient should return (or other disposition of case).
- (15.) Progress notes with changes in diagnoses (including follow-up notes).

An intelligent clerk would be capable of knowing which of the items is applicable to a certain record. The form is not, therefore, too elaborate for minor or simple cases which would not require all the items listed.

#### THE PSYCHIATRIC CLINIC AS A STORE-HOUSE OF INFORMATION

The development of psychiatric clinics, behavior problems in childhood and adolescence, treatment of neurotic children, and adolescent and older patients are some of the topics discussed by I. J. Sands, New York, who asserts that the psychiatric clinic in the general hospital supplies the long felt want of a readily accessible source of information on general psychiatric subjects for the medical profession at large. The mental clinic in a general hospital is in a position to furnish information on psychiatric subjects that are not encountered in state hospitals. There is a great need for an exhaustive study of endocrine diseases, especially in their histopathologic phases.

The country at large is at present aroused over the great wave of criminality that is sweeping over it. Everything is being offered as a possible cause of this problem, from the greatest achievement of science to the very elements of nature itself. Impossible laws, bigoted reformers, the automobile, the motion picture, the radio, lack of religious training, and even the very rays of the sun have been enumerated among the possible causes. When one considers that approximately two thirds of the population of our penal and correctional institutions have been shown by surveys to be suffering from a mental disease or defect that has a definite bearing on their antisocial conduct, it is but logical to expect psychiatrists to produce explanations for and offer solutions of this problem.

Recent tragic events have shown the importance of the recognition of the various problems in childhood long before their manifestation in overt acts of antisocial conduct. These have elicited considerable unfavorable editorial comment from the lay press. Recently, psychiatric opinion has been subjected to severe criticism because of the diametrically opposed views which alienists have offered in some of the notorious medicolegal cases, and also because the poor person is frequently deprived of expert psychiatric opinion that is purchased by the rich.

The first criticism can be combated by merely calling attention to the fact that difference of psychiatric opinion as compared with difference in legal opinion is like an harmonic symphony compared with a rhapsody of incoherence. The second criticism may ably be combated by the psychiatric clinic in a general hospital, which would be in a position to offer expert advice to the poor. The presence of the psychiatric clinic in the general hospital is assured. The success and failure of any one given clinic will depend on its personnel. The director of the clinic must be a psychiatrist of wide experience and special aptitude for his work. The study of mental disorders requires a long apprenticeship, and there are no shortcuts for acquiring psychiatric knowledge and experience. A six months' course of training in a foreign country in one of the many modern schools of psychology or psychopathology is surely inadequate to enable a man to assume leadership of such a clinic. A properly trained psychiatric social service worker is likewise indispensable for the success of the clinic. A properly trained psychologist is a very desirable addition to the personnel. Properly kept records and proper clerical assistance, will enhance the value of the clinic.—*Journal of the American Medical Association*.

#### "THE HUMAN FACTOR"—NEW INDUSTRIAL RELATIONS BULLETIN

The Massachusetts Society for Mental Hygiene announces that it will publish regularly as a definite part of its program, a new bulletin, "The Human Factor."

It will be expressly gotten up for the busy executive in business or industry, and will be largely concerned with the innumerable everyday problems of industrial relations.

It is intended that this bulletin will appeal strongly to employers, personnel workers, educators in stores or factories, management executives, employment managers, physicians, and all others who are in any way concerned with the human factor in business or industry.

The publication, which will generally consist of from four to six pages, will at first be issued quarterly. It will be under the editorial direction of Dr. Henry B. Elkind, medical director, Massachusetts Society for Mental Hygiene, Boston, Mass.

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There are many Pituitary extracts on the market of varying strength and in order to be sure of your product, we suggest the advisability of insisting on a dependable make and commend to you ARMOUR'S because of the opportunity which our facilities make possible in the selection of raw material.

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SATISFACTION lies in strength, sterility and uniformity of absorption, features to be attained only when the smooth or detached side of selected sheep gut is employed. Right now the price of raw material is very high. Some manufacturers are evening up things by using the mesenteric as well as the smooth portion of the intestine. None of the cardinal qualities can be guaranteed when the rough side is employed. This is obvious to the man who has studied the manufacture of catgut.

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## OCCUPATIONAL THERAPY AND REHABILITATION

Conducted by LOUIS J. HAAS, Director of Men's Therapeutic Occupations, Bloomingdale Hospital, White Plains, N. Y., and MRS. CARL HENRY DAVIS, Advisor in Occupational Therapy, 825 Lake Drive, Milwaukee, Wis.

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## OCCUPATIONAL THERAPY FOR CHILDREN

By Isabelle L. Whittier, Massachusetts General Hospital,  
Boston, Mass.

THREE years ago I accepted the position as head of occupational therapy work, adult as well as children, in the Massachusetts General Hospital. This last year I have started occupational therapy work in the Eye and Ear Infirmary, which is connected with the hospital by an underground passage. I trust the double responsibility is only temporary. This work has necessitated the addition of one teacher student and two kindergarten students to my corps of aids. There are nine of us this year, working in the two institutions.

Keeping track of all the work, makes necessary a weekly experience meeting of all the workers.

My greater interest is, as formerly, special work with the children, which I have been able to keep up with the extra student help.

In spite of my having said previously that good educative work in the sense of school work was impossible in the Massachusetts General Hospital, I have come to believe that it should be an important part of our program. There are two reasons for this—the result of a conversation with the doctors as to the most important time educationally in a child's life and the growing preference of our children for the more educative and practical materials. So I have been more interested, this last year, in the purely educative part of my work with children than with the simply occupational and recreational. But growth in human bodies comes with the greater development of parts. I notice that often in the growth of children's bodies, the feet, sometimes the nose, often grow for a time out of all proportion to the other parts. Then the other parts catch up. So I am only following Nature.

We used to hear from the traditional Catholic Priest: "Give me the first seven years of a child's life and don't care about the rest. He is formed."

Today we go farther than that. I quoted the priest to one of our child specialists.

"Seven years, yes, the child is practically formed by

then, but I should go farther back than that if I were speaking of the importance of early training. The first eighteen months are of supreme importance in a child's life."

Another doctor—"And I go still farther back. I am emphasizing to every young mother the necessity of training in the first ten days after a baby is born, when his mind is blank."

"But what can you do in definite training then?" I asked.

"See that he is warm, comfortable, properly fed, and tend to the forming of his regular necessary habits, and let him alone."

Now comes one who says:

"The point is that you can't begin education in the sense of training too early. It should begin preferably before a child is born, with the father and mother."

We can't do much about the training of father and mother in the children's wards, but realization of the importance of early training for children has been the keynote of my work this year.

For babies under two years, I have tried to get a few seconds of concentration, when they were well enough, by swinging a soft red ball. Instead of wandering the eyes are usually fixed on it for a few seconds, then they generally look at me. I say "Up, up, up" as I raise the ball and "Down, down down" as I lower it. Then I tie it to the side of the crib and let it swing. That is a baby's first lesson.

For children two years old, I give the Montessori insets. With these, they learn to manage their hands. At three, I use the dressing frames and bead frames. At six, the little wooden squares upon each one of which a letter is printed. Children of seven and eight, who have had a little geography in school, enjoy the puzzle maps of United States and North America. These children are ready for my teacher student. The dressing frames teach children buttoning up, hooking and lacing.

With the bead frames I teach counting. "One, two, three, four, five" I say as I move the red beads from one



Kindergartner in children's ward.

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**2.** Neater than marking ink.

**3.** Quicker than woven labels.

*—and your marking  
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Kaumagraphs are applied permanently in a second—just pressed on with a hot iron.



## The textile industry's favorite method now available to hospitals

THE seemingly little problem of marking linens has caused hospitals—and nurses in hospitals—a pack of trouble.

Some hospitals have tried expensive marking machines only to find that the mark soon washes out. Other hospitals have used marking ink, at best a messy unsatisfactory, smudgy makeshift. Still other hospitals have tried woven labels but Oh, what a job to sew them on.

Now, at last, an ideal method of marking is available to hospitals—the Kaumagraph transfer method. For 25 years it has been the textile industry's favorite method of applying marks to the selvage of silks, cottons, linens and to the toes of hosiery. For years leading hotels have adopted it as the best method of applying their

### A few of the many articles you can mark with Kaumagraphs

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—Napkins	—Personal laundry
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crest to their kitchen, table and bed linens.

Kaumagraph transfers of individual names or initials, of hospital names or crests, are applied in a second—just pressed on with a hot iron. They are indelible—they cannot wash out even after dozens of trips to the laundry. And they make a mark second only in beauty to an expensive embroidered mark.

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Additional individual names for nurses, internes, etc., \$1.00 each name for a carton of nine dozen. Send in your order now—use the convenient order coupon below if you prefer.

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Enter our order for 5,000 Kaumagraphs of our
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Teacher-student conducting a class in geography.

side of the frame to the other and again with the yellow, blue and green. Very shortly children mimic as far as the "one, two, three."

The little wooden squares with letters have been quite valuable to me in winning a newcomer of six or seven years in the ward.

"You are a new little girl, aren't you?" I say, "and I don't know your name. Will you spell it for me, and your street and town, with these letters? Then I'll know."

If I asked such a child her name, she would probably be too shy to tell me, but I go away and leave her to pick out the letters and she is eager to show it to me when it is done.

Many times this year children have asked me how to spell words in writing letters home. Then I ask them if they know how to spell another word. They ask each other if they can spell such a word and we have fallen into a spelling match, which most children love.

I found a boy of eight crying one day.

"What's the matter, John?"

"I'm afraid the other fellows will get ahead of me and I'll be left behind."

Is it any wonder then, that I wrote to Mr. Clarence M. Weed, superintendent of the Lowell Training School for Teachers, and begged him to let me have one of his students to teach our convalescing children? We have had a continuous service of several young women from that school with us all winter, each one staying six weeks

at a time. She has taught, generally, about eighteen children a day in the Massachusetts General Hospital and the Eye and Ear Infirmary, sometimes individually, sometimes in small classes.

We have a regular printed slip that we send to the child's teacher asking for information in order that we may help the child to his greatest advantage. This correspondence goes on, however, only when the child is with us a considerable time. Otherwise, we question the child and work according to his needs as we see them, without bothering the teacher.

This method of conducting the education of the children meets with their hearty approval and many of them enter the study with more vigor than do most well children.

I have often seen these children come rushing in their wheel chairs with a whoop of joy as the teacher appears at the door.

Of course there are some exceptions to this rule and sometimes children even when they are well able do not want to work. We let these children alone and very



A game of bean-bag with the smaller patients.

often they join the class when they see how the busy children are enjoying it. I confess that the general eagerness of the children to learn is often a pleasant surprise to me.

For the second children's ward in the Massachusetts General Hospital and for "The Nursery" at the Eye and Ear Infirmary, I have regular kindergarten work scheduled every day.

As I am a trained kindergartner, I watch this work and that of the teacher student and send a full report and criticism of the teaching capacity of the students to the head of the institutions that so kindly lend us their workers. I do the same for the occupational therapy pupils.

In this manner the head of that institution gains an insight into the practical work of his students and we are enabled to have our children taught easily.

Besides the two kindergarten students and the one teacher student, I have the very valuable services of one who teaches wood carving, the making of little doll's furniture, rush-bottom chairs and tables, and the tooling of leather. This work is for the boys mostly. Then there is an expert needle woman who teaches in the women's



Instruction in weaving and basketry by an experienced teacher.

## DRIVE

WHAT an obnoxious term, this word "Drive!" What unpleasant thoughts it raises of dragooning people onto committees, of getting men into corners and telling them what they *must* give! Why exalt brute force? Why crystallize and emphasize public resistance? Well-organized, carefully-conducted campaigns of public education, based on modern selling principles, are replacing "Drive" methods.

We believe the word "Drive" is a psychological blunder. We consistently avoid it, and the methods that it implies.



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to Reap

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ward; anything in the way of knitting, crocheting, tatting Italian hemstitching and all kinds of simple handwork done with a needle. Besides these I have always two or three occupational therapy students.

Much of my time is spent overseeing all this work, suggesting and trying to help the students as well as getting what seems best for the patients.

On Wednesdays, from twelve to one o'clock, we have what I call "Our Experience Meeting." We all meet and tell what we are doing. For this, I have a card telling what I want each student to report first. It runs—

- I Name of wards in which you are working.
- II Sex and age of patients.
- III Number of patients with whom you are working.
- IV Special cases.
- V Problems.

These meetings are often intensely interesting. The problems are the cases in which one doesn't know what to do next. Let me give one or two examples:

"I have a boy," one of my aides reported, "who is restless and making trouble in the wards when not busy, but he is only willing to do one thing for a few minutes at a time. Then he wants something new. I can't take time from the other patients to do so constantly for him. What shall I do?"

One of us advised, "Find out what he likes best to do, basketry, perhaps. Give him something to do in his present occupation, saying that he can't have the basket to work on until he has finished so much." The basket work was then being kept as a reward of steadiness. It succeeded and the boy busied himself sometimes for twenty minutes at a time.

For the adults there was the case of the sailor and the sisal.

In Ward A there was a sailor who had a fracture. And he was fractious. He was far enough along in his recovery to go about in a wheeled chair, but very nervous and constantly making trouble.

"Here is a case for you," said the doctor on the ward. "See if you can't give him something to interest him and keep him quiet."

I sent one of my most intelligent aids to him next day, telling her not to suggest his doing anything at first, but just talk with him and see what would be likely to interest him. She succeeded in winning him by getting him to show her how to make sailors' knots.

"And what else do you do aboardship in your off time?" she asked.

"I make door mats when I have the sisal," and his face lighted up as he said this.

"I should like to see you do that, too."

The man agreed to make mats if she would get him the sisal.

"In any ship-fitting store," he told her.

The aid asked for sisal in the nearest shop for ships. They had never heard of it—"What was it?" Another shop—no! Still another—no! She came to our Wednesday meeting and told her story. Everybody was interested and the nine of us started on a search through Boston

and environs for the now famous sisal, with no success.

For two days, sisal was in my mind for breakfast, lunch and dinner. I wondered if the sailor had been a little out of his head and made up the word. At the time, I was in the city, boarding with two nice old school teachers. I laid our difficulties before them.

"If there is such a thing as sisal, which I doubt," said one decidedly, "it will be in the dictionary."

Of course! How stupid we had been! There it was. "Sisal hemp, the American aloe, used for cordage."

The next morning I advised my aide to go to the Sailors' Home in East Boston. I believed that she might get information from some of the inmates that I had once seen over there. Sure enough! A ship was just in. The sailors welcomed her with open arms.

"Sisal!" they exclaimed, "Of course, we know it! You can get a ton of it if you like, just around the corner."

The next day our sailor began a career of mat-making that we thought nothing would stop. Luckily, he was sent home a cured man before the hospital was quite swamped with door-mats.

Besides problems, at our Wednesday meetings, we tell each other of any remarks of special appreciation of our work on the part of patients. This often gives suggestion and inspiration to the other workers.

The results of our meetings are various. We are constantly playing into each other's hands and helping each other as well as doing our individual work. We all know what everybody is trying to do and that adds to the fund of interest.

If another can put through that difficult case, I can put through mine, and I know everybody will be interested to hear and congratulate me next week if I succeed; if not, to hear what progress I have made and suggest something else. That is the resulting attitude towards the work that I find comes from our meetings.

Discussions often arise as to ways and means and we can hardly wait 'till another week to hear how some of our schemes have worked out. With nine of us to consider each difficult case, we seldom fail to find a way out.

Personally, I receive much help and inspiration from these meetings, and from them I can keep better track of what each worker is doing and thinking than I could with only my constant observation. I generally take the girls one or two at a time out for lunch during the two months that they usually stay with me and in that way I really get to know them a little.

Without these meetings, I could never have kept in constant contact with all the work of the two institutions—Massachusetts General Hospital and the Eye and Ear Infirmary this last year. As it is, I am trying to get a partner for my responsibilities for next winter.

I do feel that this extra stressing of educative work with children has been successful inasmuch as they have been eager and happy in the doing of it. It remains to be seen, probably we shall never know, how much it has really helped in the child's life.



Miss Whittier helping a child with the spelling board.

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At your service, too, is the Fischer Technical Plan and Engineering Bureau which will lay out a floor plan to fit your available space and will indicate the equipment required and its proper location.

In common with all the Fischer Educational Service, these helps are supplied without fee and place you under no obligation. You will find them most useful and the advice given is wholly disinterested.

Correspondence is invited from interested physicians and hospital authorities.

**H. G. FISCHER & CO., INC.**

*Physiotherapy Headquarters*

2333-2343 Wabansia Ave.

CHICAGO

## HOSPITAL EQUIPMENT AND OPERATION

With Special Reference to Laundry, Kitchen and Housekeeping Problems

*Conducted by HERMAN SMITH, M.D., Superintendent  
Michael Reese Hospital, Chicago, Ill.*

## HOW TO DECREASE BOILER PLANT COSTS

By Russell Byron Williams, Field Editor,  
THE MODERN HOSPITAL, Chicago.

**F**EW hospital executives are mechanically trained. That fact would not have merited mention fifteen years ago. Prior to 1910 absence of mechanical training would not have been considered a defect or handicap. Today, owing to the far-reaching advances that have been made in the mechanical world and the mounting costs of maintenance and operation, mechanical training is becoming recognized as a distinct asset. More and more attention is being given to the mechanical end of hospital operation on account of the ever increasing costs of equipment and maintenance.

Of all the mechanical departments of the hospital, none holds such great potentialities for economy as the boiler plant. Here expensive coal is consumed and more extensive steam is generated. Few processes are fraught with greater possibilities for waste than the generation of steam. Notwithstanding that fact many hospital superintendents almost completely ignore the power plant and leave the engineer alone. This policy results in coal bills ranging from 25 to 100 per cent above what they need be, in repair bills entirely unjustified, and in a rate of mechanical depreciation that would not be tolerated by any but an endowed institution.

This waste is due to ignorance caused by the lack of operating records and a proper analysis of the various items of cost entering into power plant operation.

Practical mechanical training is becoming more imperative every day. It is difficult, however, for present hospital administrators to gain this knowledge. In ninety per cent of the field, such acquisition would not be practical if it could be obtained. The thing most needed by a great many institutions is more capable engineering, not on the part of the superintendent but on the part of the power plant man. Too many hospitals are inefficiently

and uneconomically engineered; far too many hospital engineers might better be first assistants to a practical man.

During the past six months the writer has talked to more than fifty engineers in hospitals ranging from fifty to 475 beds. In every instance he has asked if a schedule for inspection existed, and, if such existed, requested a copy of that schedule and in every case the engineer stated that he had no schedule for inspection, that he had no record of repairs made or of the present status of equipment. In no plant was a CO<sub>2</sub> recorder or steam flow meter employed and in only four hospitals were automatic stokers used. Four engineers stated they had never cleaned the boiler tubes, several thought that the tubes needed cleaning about once a month while the majority made it a point to clean the boiler tubes once every week. Only three cleaned the tubes daily. In three plants, each about 300 horse power the boilers had not been down or taken off the line for a general overhauling and inspection for more than two years. In one small hospital of twenty-five beds the boiler, which was little more than a furnace, had a steam gauge that was out of operation.

Perhaps the writer's experience has been unusual, but his conviction is that hospitals in general could effect surprising economies through the employment of more capable engineers and the installation of more efficient equipment.

This does not mean elaborate equipment which might include a large battery of expensive instruments. Operated by a capable engineer, the average hospital of one hundred beds or less has little or no need for a CO<sub>2</sub> recording instrument, or a mechanical soot blower. Under ordinary conditions, in the average hospital, the boiler plant, which is probably not more than 250 horse power, does

### ANNUAL ANALYSIS

192-	Cost in Dollars								Plant Performance				
	Coal	Oil	Packing Wast	Gen Sur	Labor	Repair	Renewals	Boiler HP Produced	Average Temperat	Hrs. Exh Steam On	Hrs. Live Steam on.	Total Cost.	
Jan.													
Feb.													
Mar.													

Figure 1. Combined summary for annual power plant costs and performance.

# RESTORING THE SICK TO HEALTH AND KEEPING WELL PEOPLE WELL

---

This double function—*keeping well people well and restoring the sick to health*—is one of the reasons why the hospital idea has been so universally accepted by the American people.

*Restoring the sick to health*, while originally the only function of the hospital, is more and more being supplemented by the service of *keeping well people well*, and all over the country hospitals are taking active leadership in health educational work.

Quite properly the service of any hospital includes educational work with resident patients, out-patients, and through its community contacts—educational work to the end of preventing those abuses of right living which lead to ill balanced metabolism which so frequently shows itself through a diminished alkalinity of the blood and tissues due to an excess of acid products—*acidosis*. This excess acid is frequently observed for the first time when the patient enters the hospital or dispensary for diagnosis. It is the beneficent service of the hospital staff to go beneath the surface of things and find out the underlying causes.

Whatever may be the remote cause of hyperacidity, the simple corrective measures here discussed should be considered by those re-

sponsible for the diagnosis, treatment and care of patients in hospitals and similar institutions. Also a note of warning may well be sounded to those who are well so that they may conserve health.

Gastric hyperacidity, acidity of the mouth and other of the more obvious manifestations of acidosis are promptly counteracted by Phillips' Milk of Magnesia which has a pronounced affinity for acids, the harmless resultant compounds being readily excreted.

The increasing use of sodium bicarbonate by the public to control "acid stomach" should be considered in this connection. Only a part of the bicarbonate is effective and that portion which produces carbon dioxide may be seriously detrimental.

Phillips' Milk of Magnesia being free from carbonates does not distend the stomach nor cause flatulence of the lower intestinal tract. Its antacid action is pronounced. A given quantity of Phillips' Milk of Magnesia neutralizes almost three times as much acid as a saturated solution of sodium bicarbonate and nearly fifty times as much as lime water. Further it has the additional merit of being laxative, a quality of importance here since constipation is so frequently the underlying cause of hyperacidity.

**DOSAGE**—The usual dose of Phillips' Milk of Magnesia, as an antacid, ranges from one teaspoonful (4 c. c.) to one tablespoonful (16 c. c.). This amount should be mixed with an equal portion of cold water or milk and given half an hour after meals.

For its laxative effect, the adult dose is one to two fluid ounces (30 to 60 c. c.). The aperient action may be facilitated by giving the juice of lemon, lime or orange, half an hour thereafter.

# PHILLIPS' Milk of Magnesia

**CAUTION.** Beware of imitations of Phillips' Milk of Magnesia. The genuine product bears our registered trade-mark. Kindly prescribe in original 4-ounce (25c bottles) and 12-ounce (50c bottles) obtainable from druggists everywhere.

*Prepared only by*

THE CHARLES H. PHILLIPS CHEMICAL CO., New York and London

DATE	MONTHLY REPORT												MONTH OF:	192
	COAL	WATER	ELEV.	HEATING	LAUNDRY	KITCHEN	MISCELLANEOUS							
1	Pounds	Gallons												
2	Pounds	Gallons												
3	Pounds	Gallons												
29														
30														
31														
Total														

Figure 2. Detailed monthly report form to be submitted by engineer to superintendent.

not justify an expensive stoker or a feed water heater and regulator. In the interests of economy and efficiency, however, such equipment is more than justified in the larger plants. There is no boiler, irrespective of size, that should not be given at least one internal and two external inspections each year; no boiler tubes that do

METER	PRESENT READING		LAST READING		ELAPSED TIME HRS.	QUANTITY USED, GALL.
	DATE	HOUR	DATE	HOUR		
CITY SUPPLY						
BOILER FEED						
HOUSE SEWER						

Figure 3. Form for recording water meter readings.

not need cleaning at least once each day; and no engineer but who needs accurate knowledge of his CO<sub>2</sub> contents obtained by means of the simple, compact and inexpensive hand testing set. Competent engineers would not think of conducting a boiler room or a power plant in the manner set forth in the above paragraph.

In the absence of efficient practice on the part of the engineer and businesslike interest in the power plant on the part of the superintendent, hospital engineers as a class have become more or less isolated from the whole organization. Only occasionally are they called to sit in the periodic conferences of the department heads; in the great majority of cases they are little more than glorified janitors. True, they perform the function of running the boiler plant and that plant has, for the most part, rendered trouble-free, continuous service. But what has the power plant earned? Has it paid its way? Or is it just a necessity that is tolerated because it must be? What does it profit a hospital to save a thousand or fifteen hundred dollars a year on the salary of the engineer and waste from ten to twenty per cent of all the coal consumed?

Keeping the plant running is not all there is to the business of boiler plant operation. Continuous records must be kept in order that costs can be determined. Improvements or additions can be made properly and at the

## DAILY OIL, WASTE AND SUPPLY RECORD

DATE	CYLINDER OIL		ENGINE OIL		KEROSENE		GREASE		WASTE		RAGS		PACKING		BOILER COMPOUND		
	GAL.	@ VAL.	GAL.	@ VAL.	GAL.	@ VAL.	GAL.	@ VAL.	LB.	@ VAL.	LB.	@ VAL.	LB.	@ VAL.	LB.	BBL.	@ VAL. BBL.
1																	
2																	
3																	
4																	
28																	
29																	
30																	
31																	
Total Receipts.																	
Total Drawn.																	
On Hand																	

Figure 4. Form for recording receipts and expenditures of lubricants and supplies. When totaled, it also serves as a perpetual inventory of both value and volume.

December, 1925

THE MODERN HOSPITAL

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# Clow is Moving Into the World's Largest Plumbing Plant



**D**URING the month of December, James B. Clow & Sons moves into its commodious new quarters at Lake, Talman and Fulton Streets, Chicago—the largest plumbing plant in the world.

Three large buildings, modern and roomy have been specially fitted for the efficient carrying on of Clow's plumbing business. The total length of the entire plant is 724 feet—width is 147 feet—total ground floor space is over 80,000 square feet.

Storage and shipping facilities are beyond parallel. For example, the capacity of the new steel and wrought iron pipe warehouse is 3500 tons. The switch track accommodates ten cars. And, twelve trucks can be loaded simultaneously.

With these, and the many other facilities that the new plant affords, the Clow organization hopes to make even better the service which has been synonymous with the name Clow for the past forty-eight years.

**JAMES B. CLOW & SONS**

534-546 S. Franklin Street, Chicago ~ Sales Offices in Principal Cities

After Jan. 1st, direct mail to P. O. Box N. N.

PREFERRED FOR EXACTING PLUMBING SINCE 1878

# CLOW



# A formula for cereal gruel in difficult feeding cases

Whole milk to the amount of 100 c.c. per kilogram of body weight, with an equal amount of water before 6 months, and 16 gm. of cereal, with a gradual increase to 48 gm. up to 6 or 7 months. This is all cooked together in a single boiler for 15 to 30 minutes. The evaporation loss is made up after cooking by the addition of water to the amount required, after which from 20 to 32 gm. of sucrose is added, or 48 to 80 gm. of dextromaltose and the whole amount divided into five bottles for the day's feedings at four hour intervals.

One baby specialist who has had outstanding success with cereal feeding treatment, illustrates the use of it as follows:

"If we had a child four months old, weighing 4,600 gm., we gave 450 c.c. of water, and added 16 gm. of cereal, cooking this for 15 minutes in a single boiler and adding enough boiled water after cooking to make a total of 900 c.c. To this we added 20 gm. of sucrose and divided it into five bottles of 180 c.c. each. The milk and cereal were increased as the weight advanced, the milk after 5 or 6 months gradually replacing the water, until at 11 or 12 months, whole milk was given."

Cream of Wheat is being used more and more as the basis of this increasingly successful treatment.

Physicians choose Cream of Wheat, first, for its high carbohydrate content; second, for its simple, easily digested form. The carbohydrates of Cream of Wheat are completely utilized and require little energy for digestion.

Another thing physicians appreciate about Cream of Wheat is its uniform quality the year round and its complete safety from any form of contamination.

This is due to exceptional protective measures given in milling and packaging. Cream of Wheat is given a sterilizing heat treatment and then is triple wrapped and triple sealed in a box which is impenetrable by dirt and weevils.

In food content, in form, in safeguarded quality, Cream of Wheat answers in an unusual degree the requirements of physicians for a safe nutritious food, valuable alike for sick and well.



# Cream of Wheat

Cream of Wheat Company, Minneapolis, Minnesota  
In Canada, made by Cream of Wheat Company, Winnipeg

FOR 30 YEARS A STANDARD FOOD ON DIET LISTS

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time required only when correct analysis of costs has been made. There are no secrets in the matter of producing steam or burning coal, or about the generation of electricity or the amount of heat steam contains at a given pressure. But there are many misapplications made and many excessive costs endured because records and cost analyses are lacking.

Unfortunately, we are not in a position to illustrate the value of plant records by actual hospital practice. Such an illustration is impossible owing to the inadequacy or total lack of figures found in hospital power plants. For this reason it will be necessary to go a-field and look at the records from a large public museum. The requirements are hardly comparable, since the museum is interested only in heat and light, not needing high pressure steam for sterilizers, laundry or kitchen. No power plant cost records were kept during 1924, but with the addi-

	Rate per Hour	Total Hrs	Amount \$	Remarks
Engineer				
Assistant Engineer				
Fireman				
Nightman				
Other help				
<b>Total gross labor costs -</b>				
<b>Deductions for maintenance for power house equipment</b>				
Description of work	Name of workman	Rate per hour	Total Hrs	Amount \$
Name of kind equip. of work				Remarks
<b>Total - power house maintenance -</b>				
<b>Deductions for construction and repairs out of power house</b>				
Description of work	Name of workman	Rate per hour	Total Hrs	Amount \$
Location	Kind			Remarks
<b>Total - out of power house work -</b>				

Figure 5. Daily report sheet for power plant labor that classifies work and shows the actual time devoted by engineering force to other than power plant equipment.

tion of an adjoining building and the need for more power, a cost recording system was established and accurate figures maintained. The results of the cost analysis that was made are best shown in the following comparison.

During 1924 361,845 KW. were generated with 2,853,000 pounds of coal; while during 1925 465,527 KW. were generated with 3,211,500 pounds of coal. Solely because of the revelations from cost analysis, this institution increased its kilowatt-hour generation 27½ per cent with an increase of 12½ per cent in coal consumed.

While it is quite unnecessary for the superintendent to be a trained engineer, it is most imperative that he or she be supplied with correct figures of power plant costs and production. One does not have to be mechanically minded to understand excessive costs and any capable administrator can point out leaks and take steps toward their correction when they are contained in weekly, monthly or annual reports.

In the establishment of recording systems for the hospital power plant it will not be necessary to carry forward such an involved set of figures as is seen in many indus-



New \$600,000 Addition to Deaconesses Hospital, Cincinnati, Ohio, financed under the Ehler Volunteer Gift Plan.

## How Will You Finance Needed Hospital Improvements?

THAT new addition which is so urgently needed, or perhaps a laboratory and its complete equipment which have been long delayed—these and other necessary improvements need not be postponed indefinitely for lack of funds. A scientific, well-directed campaign to raise the desired money may be all that stands between you and the realization of your plans.

The reputation of this organization for raising money for Hospitals, Colleges, Chambers of Commerce and similar legitimate activities is as widespread as it is noteworthy. We employ scientifically trained men to manage our campaigns, which are noted for the dignity of their appeal and the spirit of good will they leave behind.

*We invite inquiries from Hospital Boards and Superintendents interested in raising money for improvement projects. Our booklet, entitled "SUCCESS IN RAISING MONEY," contains facts of unusual interest regarding our service. Send for a copy.*

**Herbert B. Ehler & Company, Inc.**  
15 Park Row, NEW YORK





## Miami Biltmore adopts HENRICIS

THE complete equipment of Henrici Washers now being installed in the new Miami Biltmore hotel brings the total of Henricis in Biltmore hotels up to 24.

These finest of all metal washers have been adopted in the Biltmore chain of superlative hotels because they give—

*Better and more uniform work,  
More production for floor space  
occupied,*

*Great savings of water, steam,  
labor and supplies,*

*Longer life with less repairs.*

For all laundry work, Henrici Washers represent the highest point yet reached in quality and volume of production, and economy.

May we send you more information?

HENRICI LAUNDRY MACHINERY CO., Boston 26, Mass.

# HENRICI WASHERS

SPEEDY - ECONOMICAL - DURABLE

trial plants. There should be, however, a comprehensive monthly report submitted by the engineer, from which the accounting department, or auditor, can make up an accurate annual report. The monthly reports should be sufficiently detailed to furnish the superintendent a complete picture of power plant operation, while the annual report should be comprehensive enough to permit of definite analysis and serve as a guide for the allotment of future budget percentages.

Data necessary to calculation of Power plant costs			
(A) Cost of Production			
Variable Charges	(1) Cost of Fuel (2) Cost of Water (3) Cost of Oil, waste and supplies (4) Cost of Labor (5) Cost of Repairs (6) Cost of Renewals		
Fixed Charges	(7) Cost of Obsolescence and Inadequacy (8) Cost of Insurance (9) Cost of Taxes or rent (10) Cost of Interest on investment (11) Cost of Management (overhead)		
(B) Output (A) Cost of Production	(12) Amount of Steam delivered (13) Amount of Power delivered (14) Amount of Water delivered (15) Amount of Ice delivered		
	Annual Depreciation		
	(Upkeep Costs)		

A simple yet practical form for the annual report given below is one which we believe can be prepared by every hospital of over fifty beds and which will prove of distinct benefit if adopted.

### ANNUAL POWER PLANT REPORT

Items	Cost	Per cent of Total Cost
(1) Coal .....	\$00,000.00	00
(2) Operating labor .....	00,000.00	00
(3) Repairs and maintenance .....	0,000.00	00
(4) Lubricants and supplies .....	0,000.00	0
(5) Water for plant .....	0,000.00	0
Total for 12 months .....	\$00,000.00	000
Coal burned, tons .....	0,000.	
Total steam produced, pounds.....	0,000,000.	
Pounds of steam generated per pound of coal .....	0.00	
Total steam used for cooking and kitchen .....	000,000	00
Total steam used for laundry .....	0,000,000	00
Total steam used for sterilizers and house .....	000,000	00
Steam made per 100 lbs. of coal....	00.00	
Coal cost per 100 lbs. of steam made, cents .....	.00	
Boiler room labor cost, per ton of coal burned .....	.00	
Electric energy generated per kw. hr.0,000,000		
Coal of electric energy generated, per kw. hr. ....	0.00	
Engine room labor cost per kw. hr. generated .....	.00	
Space heated, cubic feet.....	000,000	
Total power plant cost per cu. ft....	0.00	
Cubic feet of space per bed.....	000	
Total cost of power plant per bed... .	00.00	

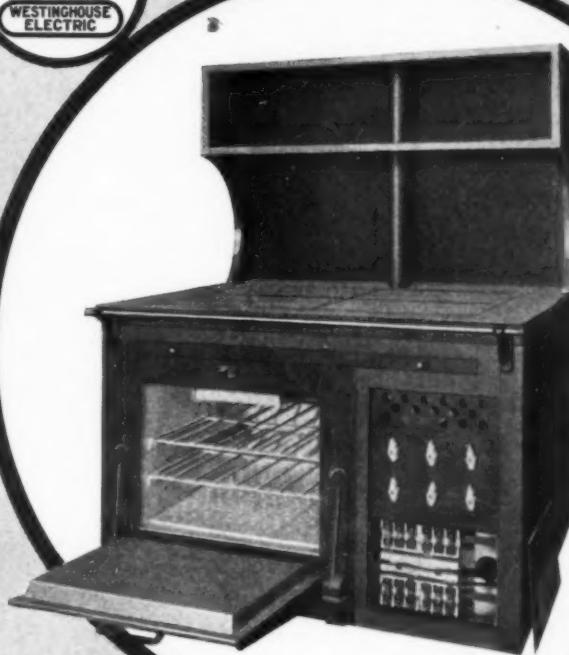
In many hospitals, largely because all electric current is purchased from an outside source, the tenth and eleventh items will necessarily be deleted from this form. Another record form which provides distinction between annual costs and performance is shown in figure 1. With such an analysis of costs, it would be a simple matter for the superintendent to note and correct leaks, to compare current performance with the performance of former years and, in the event he or she were in doubt, to turn the report over to a recognized engineer for an expression of opinion.

Such an analysis would be impossible to develop with-

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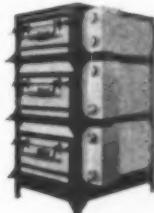
The Westinghouse Electric Range, showing roasting oven interior. Fuse-block cover is removed, showing fuses and terminal connections.



The Westinghouse Electric Broiler is an efficient, compactly built unit, of generous capacity. Has three-heat control. The grid is easily operated by means of a lever. A convenient warming oven located above the broiler uses heat which otherwise would be wasted. Rigidly constructed throughout. If desired, it can be supplied with an insulated roasting oven underneath the broiling compartment.



Each section of the Westinghouse Electric Waffle Iron bakes a large four-part waffle every two minutes. The temperature is automatically controlled. Every waffle is evenly baked. This Westinghouse Appliance is constructed of aluminum, with heavily nickelated parts. Very convenient.



The Westinghouse Electric Bread Baking Oven bakes delicious bread, pies, pastries of all kinds. Each section can be operated at a different temperature. Roasting sections for meats can be added.

## For the Modern Hospital Kitchen

Above all else, modern hospitals are clean. From main entrance to kitchen, methods and equipment unite in maintaining their unvarying standards of cleanliness. For which, thank electricity with its many useful applications.

Take the kitchen. There's Westinghouse Cooking Equipment—the electric range, broiler, breadbaking oven and automatic waffle iron. All time-tested, easy to operate, clean, quick, economical. And as to electric cooking results—ask the Chef!

WESTINGHOUSE ELECTRIC & MANUFACTURING COMPANY  
EAST PITTSBURGH, PA.

Sales Offices in All Principal Cities of the United States and Foreign Countries

# Westinghouse

## ELECTRICAL COOKING EQUIPMENT

## Beautiful Waxed Floors

*this new easy way*

**Now You Can Wax  
your floors QUICKLY  
—without stooping  
—kneeling or soiling  
your hands**

### POLISH FLOORS ELECTRICALLY

This Electric Floor Polisher is a marvelous, new machine that instantly and without labor brings waxed floors and linoleum to a beautiful high gloss.

Simple! Compact! Light in weight. Easier to operate than a vacuum cleaner. Runs from any light socket for less than 2c an hour. It polishes under buffets, davenport, beds, etc., without moving the furniture. Sturdily built to last a lifetime and guaranteed absolutely.

#### Wax Preserves Wood

"Wax is like armor for floors—tramping feet never actually touch the floor. And after a floor has been waxed the daily cleaning is simple. Wet mopping is entirely unnecessary.

*Every evening simply remove the surface dirt by sweeping. Re-waxing may be necessary on the main traveled areas once or twice a month. A scrubbing should be required not more than two, three or four times a year.*



**\$42.50**

COMPLETE READY  
TO OPERATE

## UNIVERSAL HOSPITAL SUPPLY CO.

500-510 North Dearborn Street  
CHICAGO, ILL.

Write for Complete Catalog of Guaranteed  
Hospital Supplies and Equipment

out periodic reports from the engineer throughout the years. For many hospitals, particularly those of smaller size, a monthly report would serve all practical purposes. A suggested form is given below for this monthly report:

Items	Total	Cost
(1) Fuel .....	000.00	
(2) Labor costs (sal's, inc. niteman)		\$000.00
(3) Repairs and maintenance (must be completely itemized).....		000.00
(4) Lubricants and supplies (itemized into every item) .....	00.00	00.00
(5) Water .....	000.00	
Steam produced—total in pounds	00,000.00	
Steam produced—per lb. of coal..		00.00
Average load carried throughout month .....	000	
Minimum load carried in month .....	00	
Maximum load carried in month .....	000	
Average daily evap. of water....	000	
Average daily consump. of coal..	000	
Kw. hr. generated .....	000	
Pounds of coal, per kw. hr .....	000	
Total steam required by kitchen	00,000	
Total steam required by laundry	00,000	
Total steam required by sterilizers and house .....	00,000	
Total space heated, cu. ft.....	00,000	
Total ash produced, pounds.....	0,000	
Per cent of ash produced as against total coal burned....		0.00%

This report should be fully detailed in respect to "repairs and maintenance" and "lubricants and supplies." Such itemization should be inclusive of not only the material purchased and received during the month, but of the material expended, place and character of repairs, and all other pertinent information. Only through itemization and detailed statements can the superintendent obtain a complete picture of boiler plant activity and properly control its operation. A more comprehensive monthly report form is shown in figure 2. This is one that divides and classifies the figures more closely in accordance with usage. This form, when properly used, provides the best possible picture of power plant performance.

In order that the engineer may turn in such a monthly report of power plant performance, he will necessarily keep for his own guidance various daily records. These are of varied forms and must be made up to conform to the individual plant. Obviously a complete record system cannot be set up for the entire field since what would be required by one plant would be useless for another. We have given, however, a few typical forms for daily use that may serve as suggestions and guides in the establishment of a system of records.

Figure 3 shows the form necessary for the recording of watermeters and water usage. Figure 4 is a self-explanatory form covering boiler plant oils and supplies. Figure 5 is a typical form for the recording of labor hours and costs, and is one which simplifies the work of deducting from power plant costs, the value of the time the engineer or his men spend in other than power plant work.

There is probably no field of endeavor using a similar amount of power that offers better opportunities for economies or low production costs than the hospital field. Yet in this one finds an astonishing number of power plants where records, if not entirely missing, are in a deplorable condition. Because hospital power plants are not different from the power plants of other institutions, and because the generation of steam and the production of power is the same wherever found, it would seem the better part of wisdom to employ competent engineers, or at least call in, periodically, a recognized en-

# By the Hundreds Hospitals Write~

## "We prefer Utica Sheets"

From all over the country came the replies. Hardly a state in the Union but was represented. And with a unanimity that was not surprising to those who know Utica Sheets, the reason given for their choice was this:

*"Utica Sheets withstand the hard usage peculiar to hospital service. It is real economy to use them!"*

In some cases these hospitals have never used any sheets and pillow cases but Utica. In other cases the decision to specify this brand was made after comparative tests. So the management of these hospitals know whereof they speak.

*~and this is what they write~*

California—

"We have been using Utica Sheets for several years. I am very partial to them and always specify them when ordering".

Iowa—

"We do use Utica Sheets and Pillow Cases, and have always found them satisfactory in every way. We feel that real economy is effected only by purchase of the best materials".

Kentucky—

"I can be quoted as being more than satisfied with their quality and service".

Maryland—

"We have used them for years and think they hold up extremely well under frequent launderings and unusual requirements peculiar to hospitals".

Minnesota—

"We have standardized on this brand."

New Jersey—

"We prefer Utica for hospital use".

New York City—

"None better".

New York State—

"They stand the wear and tear of frequent launderings exceedingly well".

Pennsylvania—

"We find that they withstand the laundry better than any sheet we have heretofore used. They are the most satisfactory that we have been able to purchase".

Virginia—

"I have used Utica sheets for a number of years and find them most satisfactory".

Every other hospital in this country can bring about the same satisfying economy by specifying Utica Sheets and Pillow Cases on all future orders.



*"Greater Economy in Sheets and Pillow Cases" is the title of an interesting booklet which every hospital management ought to have. Your written request will bring it, free, and without obligation.*

**UTICA STEAM & MOHAWK VALLEY COTTON MILLS**  
**UTICA, N. Y.**

# UTICA Sheets and Pillow Cases

REG. U. S. PAT. OFF.

When using advertisements see Classified Index, also refer to YEAR BOOK.

## Attracting Nationwide Attention for Infant Feeding

LEADING pediatricists are recommending Karo (Corn Syrup) for modifying and enriching whole lactic acid milk for infant feeding.

From a recent report:

"Recently we have given 6 new-born babies whole lactic acid milk with Karo one ounce to the quart as a complementary feeding when we have found the maternal milk supply inadequate after the fourth day, and when we have been unable, by emptying the breast after each nursing by manual expression, to increase the supply sufficiently. They apparently digest this milk with its 3.5 to 4 per cent fat and its 3.5 per cent protein, and do well on it without signs of gastric or intestinal indigestion."



*Note:* For the past 20 years Karo has been sold by grocers throughout America.

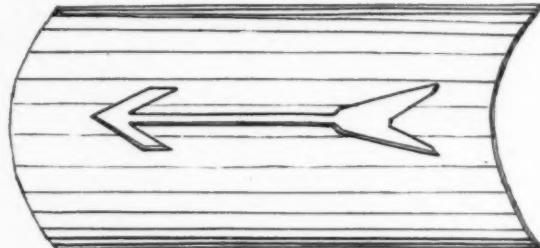
There are three kinds of Karo—Blue, Red and Orange label—all are equally nutritious.

Engineer for consultation and inspection. Very often such an engineer will be glad to give consultation service without cost, since there would accompany such service the satisfaction of having benefited those engaged in the most worthy endeavor known.

In an early part of this article we mentioned the fact that, so far as our knowledge extends, no schedule for inspection exists. We will, therefore, endeavor to set up a schedule of this kind in a separate article to be published in an early number of THE MODERN HOSPITAL.

### IDENTIFYING PIPE LINES

Because power plants are necessarily characterized by a veritable forest of piping, each pipe serving its own purpose by conducting any one of a number of power plant products, identification of some kind is needed. Particularly is this true where the hospital power plant is located in a separate building and both flow and return lines must proceed underground to the main and auxiliary buildings.



Arrow stencil for identifying pipe lines and indicating direction of flow.

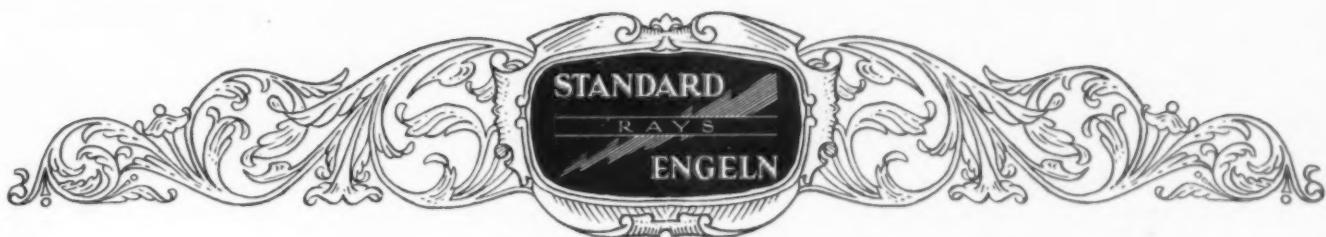
To the end that these pipes might be properly identified the American Society of Mechanical Engineers has recommended a paint color scheme, inasmuch as all pipes require a paint covering. The proposed color scheme is as follows:

Steam .....	{ High pressure .....	white
	Exhaust .....	buff
	{ Fresh, low pressure .....	blue
Water .....	Fresh, boiler feed .....	blue and white
	Salt water .....	green
Compressed air .....		gray
Fuel oil .....		black
Gas .....		aluminum
Refrigeration (brine) .....		White and green

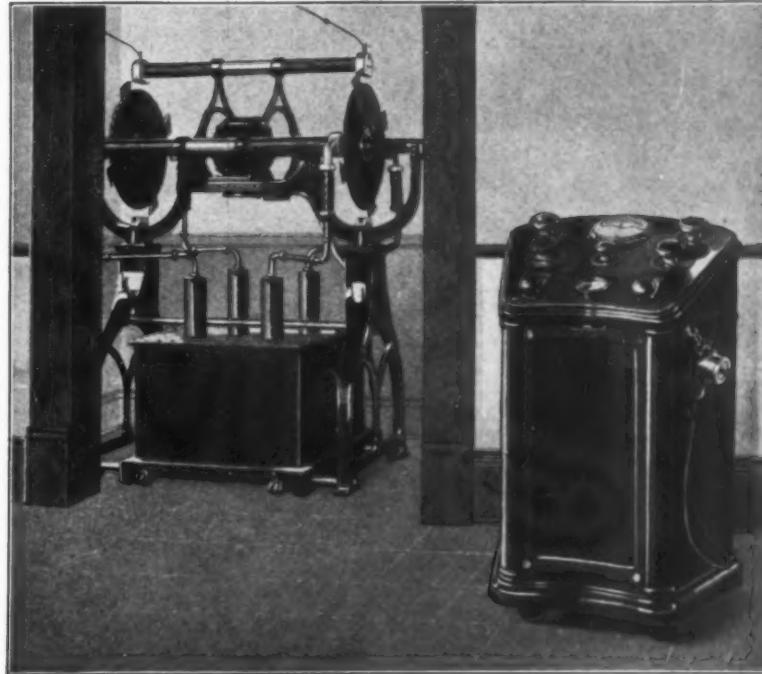
Although these recommendations were made several years ago, power plant engineers have never universally adopted the proposed system. There is invariably opposition to the cost of cleaning and properly painting pipe lines with identifying colors, notwithstanding the fact that the initial cost would be the only expense and that a distinct saving in workmen's time would result.

An alternative is suggested, therefore, in the form of a stencil, similar to the one shown in the accompanying line drawing. This stencil obviates the necessity for cleaning the entire pipe, yet provides a means for employing the identifying color scheme of the A. S. M. E. The arrow, furthermore, has the added advantage of indicating the direction of flow.

The steward of a Southern hospital finds that it is of interest and value to know the prices paid for foods at different periods of the year. To make this possible he keeps a loose leaf book in which he posts the prices paid for various foods from day to day. This also helps him to understand some of the trends and tendencies that cause an increase or decrease in raw food prices.



**A  
New  
Safety  
and  
Power**



## De Luxe X-Ray Equipment

THE new De Luxe line of Standard Engeln X-Ray equipment is, in design and construction, the work of master craftsmen. One of the many new and valuable features which the new equipment includes is that of Safety—Safety for both Roentgenologist and patient from serious electrical shock or burn whether the equipment is operating at the enormous voltages used in Deep Therapy or at the lighter currents used in Fluoroscopy. This Safety is secured by a new and patented transformer design which supplies a maximum of energy for this type of work. The Radiographic field is entirely separate and its super-power windings furnish sufficient energies for any Radiographic technique, including the new 100 milliampercere tubes. Our explanation of these epoch making features and a full description of the equipment will be sent at your request.

### THE STANDARD ENGELN CORPORATION

*Diagnostic and Therapeutic Ray Equipment*

Superior Avenue at East Thirtieth Street, Cleveland, Ohio

Standard X-Ray Company  
Chicago, Ill.

The Engeln Electric Company  
Cleveland, O.

DOCTOR	-----
OFFICE	-----
CITY	----- STATE -----

18

When using advertisements see Classified Index, also refer to YEAR BOOK.



## What they will eat

*Prescribe Puffed Grains to coax appetite back*

WHEN convalescents refuse to take an interest in food, Quaker Puffed Grains often help coax back appetite.

Puffed Wheat and Puffed Rice are tempting dainties when offered with sugar and cream, or floated in a bowl of milk. They are so light, so airy, so delicately fragile, that it is hard to realize that they are such nutritious grains — rich wheat and rich rice — steam exploded to eight times normal size!

This breaking up of every tiny food cell assures easy digestion and assimilation. And, equally important, enjoyment of Puffed Grains encourages the liberal allowance of cream and milk so necessary in body-building.

Children enjoy Puffed Wheat and Puffed Rice, regarding them as confections which they are allowed to eat without restraint. When your little patients rebel at their daily allowance of what seems to them plainer, heartier food, advise mothers to make breakfast and luncheon seem more attractive by the introduction of Quaker Puffed Grains.

**Quaker Puffed Wheat  
Quaker Puffed Rice**

### LEARNING FROM INDUSTRY

EVER since 1905, when labor costs began to increase, industry has learned that it pays to automatize processes. It was soon discovered that machinery could turn out many products faster, better and more cheaply than hand labor. The result of this adaptation of machines has been to increase the production of manufacturing plants six times. In other words, two men are now producing six pieces where they formerly turned out only two. Solely because of better methods and the adoption of mechanical devices every workman is today producing three times as much as he did in 1900.

There are many industrial procedures developed during the past ten or fifteen years that hospitals might well adopt. The fact that the number of hospital employees, per bed, has not shown a reduction during the past fifteen years would indicate that our institutions have not taken advantage of the more modern methods—that the



A compressed air paint sprayer that cuts labor costs one-fifth

adoption of at least some of the procedures now common to industrial plants is needed in many of our hospitals.

The writer fully appreciates that there is little possibility of comparing hospitals to industrial organizations. We can, by observation and analysis of commercial methods, however, learn much of benefit. The principles of power plant practice are the same whether that plant is serving a hospital or a university. Methods employed by large restaurants or hotel kitchens can be applied, with reservations, to the hospital dietary. In the matter of housekeeping much can be learned from the management of large office buildings.

When it is known that the engineer of a 300 h.p. boiler plant has effected appreciable economies through the use of a mechanical soot-blower, it would pay to investigate the methods of that engineer regardless of where he might be employed. If it is learned that a hotel kitchen saves ten per cent of the gas bill by piping hot water from the boiler plant direct to the ranges, it would be good judgment to make an analysis of the conditions to determine whether a similar saving might not be effected in the hospital kitchen. In the majority of large office buildings, the obsolete mop and pail has been superseded by electric floor scrubbing machines, with a resulting economy in labor costs reaching into the hundreds of dollars. With this saving in mind it would seem wise for the hospital superintendent to make some research in an effort to learn which was the more objectionable —the hum of the motor or the clattering of the scrub woman.

The cost of painting is a minor item to both hospitals and industrial plants. But minor items warrant a pro-

# NEVERTEAR SPREADS AGAIN TRIUMPH



CHESTER COUNTY HOSPITAL, WEST CHESTER, PENNA.

Those people who have seen the new Chester County Hospital at West Chester, Penna., claim that it is one of the finest and most up-to-date hospitals in the country.

This hospital was donated and equipped by Mr. Pierre S. DuPont of Wilmington, Del., and equipped with the idea in mind that nothing but the best quality merchandise would be used.

Bidding against fifteen competitors we were awarded the entire contract for supplying the blankets, linens and bedding.

The spreads selected were the Nevertear Spreads which proved themselves again to be the best hospital spread obtainable and the most economical in the end.

Let us send you samples and quotations on your requirements at this time. An order for one piece of goods will receive the same careful attention as the entire equipment of a new hospital.

**JOHN W. FILLMAN CO.**  
**1020-24 Filbert St., Philadelphia, Penna.**



## SUCCESS and SERVICE

Are registered by the testimony of satisfied clients. If you contemplate a campaign for funds think this over. Kern-directed drives continue to command the approval of the clients served. Within recent weeks, enthusiastic approval of the work of this organization has been filed from widely scattered communities from Passaic, New Jersey, to Pueblo, Colorado. Comes now the verdict upon a Canada campaign just concluded:

**SHERBROOKS HOSPITAL**  
Sherbrooke, Quebec

October 16, 1925.

Mrs. Mary Frances Kern,  
1340 Congress Hotel, Chicago, U. S. A.

Dear Mrs. Kern:

I was authorized at a meeting of the Committee today to express our satisfaction and appreciation of the work done by your organization.

Your representatives have set up a working force of several hundred men and women in the City of Sherbrooke and extended the organization to twenty-one other centres in the Eastern Townships including a total of over thirty towns.

While the unseasonable blizzard and bad weather has delayed the work and returns from the outside communities, the first returns at our luncheon meeting on the 14th shows that the committees in these neighboring towns are functioning effectively and will yield sufficient sums to help our totals very substantially.

We feel that every thing has been accomplished that could be and the expenses through economical management, have been kept \$1,000 within the original estimate.

The publicity has been very fine and far reaching and aside from the fund raised cannot help but be beneficial to the Hospital in establishing the institution in its proper place in the minds and hearts of the extensive community which has been campaigned.

Very truly yours,  
W. E. PATON,  
General Chairman.

## MARY FRANCES KERN Financial Campaigns

1340 Congress Hotel  
CHICAGO, U. S. A.

8 West Fortieth St.  
NEW YORK, N. Y.

73 Adelaide St., West  
TORONTO, CAN.

portionate amount of attention to that given the larger expenses, because small items invariably reach startling totals when considered in the aggregate. A good example of the ability of small items to pyramid into enormous totals is found in this single item of paint and painting costs.

Only the very large hospitals use what might be considered a great amount of paint. The average hospital uses less than forty gallons of varnish, sixty-five gallons of flat wall paints, or fifty gallons of enamel a year. Yet the total paint used by the entire field is in excess of 1,750,000 gallons. To be specific: the combined hospitals of the United States, comprising some 6,700 institutions, annually use 241,000 gallons of varnish, 429,000 gallons of flat wall paint, 308,000 gallons of enamel, and more than ten million pounds of white lead. Since it requires an average of twelve and one-half pounds of white lead to the gallon of paint, the annual expenditure of white-lead paint in this field is more than 800,000 gallons. These divisions, added together, give a total of 1,778,448 gallons, the amount used by the hospital field every year.

These figures were obtained from an analysis of the paint requirements of twenty-seven representative institutions. The hospitals chosen for this analysis afforded an accurate cross-section of the entire field, so that, while the figures might conceivably vary a few thousand gallons, the total is approximately accurate.

By far the greater portion of this paint is applied by hand and hair brushes. This means that it is costing hospitals an average of one dollar to cover 144 square feet of surface. If the entire field could be brought to use paint spray guns, and all the paint be applied by air pressure, that cost would be reduced to a figure only slightly in excess of sixteen cents. At present the field is paying painters more than five and one-half million dollars every year to apply this paint. Equipped with spray machines, this expense would be reduced to less than \$850,000.

That statement may be astonishing but it is incontrovertible. There are few places where paint need be applied by hand, now that reliable automatic equipment is available at a price within the reach of almost every institution. The saving effected by this mechanical means is calculated as follows; the figures being based upon exhaustive analyses of all costs, as taken from more than sixty jobs.

Hand brushing 456 sq. ft., 3 hr. 10 min. at \$1 per hr..	\$3.17
Air brushing 456 sq. ft., 20 min. at \$1 per hr.....	.34

Gross saving in labor costs by air brush, per gallon.	\$2.83
Cost of paint by hand brush .....	.180 .20
Cost of paint by spraying unit .....	2.00 .20

Net saving effected by mechanical means, per gal... \$2.63

When it is possible to save \$2.60 or more per gallon of paint applied, there is little justification for the continued use of the hair brush. The saving in paint by this method does not offset the saving in labor costs that are effected by air pressure application.

If this per gallon saving could be applied to all the paint used by the entire field, more than \$4,500,000 would be realized to use in other and more needed investments. Calculated by the average paint requirements, mechanical application would save about \$650 per year per institution. Some of the larger hospitals would save far more than this amount while others would save only a fraction thereof. For the average institution, throughout the field, however, the figures of \$650 would apply. And since the paint spray outfits cost no more than \$350 at the most, it would seem that hospitals have here an experience



*The Main  
Dining Room*

Hyde Park  
Hotel • Chicago

## Where the Spirit of Hospitality Reigns

The Hyde Park Hotel, the pioneer hotel of Chicago's south side, has long been a home for discriminating residents and a haven for travelers from all over the country. Under the management of Robert E. Clarke and Harry E. Spear, it has become famous for its home-like atmosphere and for the care and comfort maintained for guests, both permanent and transient.

The dining room at the Hyde Park Hotel is the largest single dining room in Chicago. In keeping with the beauty of this room is the excellence of the cuisine—a delight to those who enjoy good things, well served, amid pleasant surroundings. Fruits and

vegetables appear on the tables the year 'round virtually as fresh and appetizing as if direct from garden or orchard, the flavor and quality preserved by Sexton's exacting standards of selection and packing.

Hotels, hospitals, and institutions everywhere know that it is not only good service but good business to serve quality foods—hence the growing number of Sexton patrons among those who serve many people each day. At this season of the year, Edelweiss Mince Meat is a popular item for menus. Have you tried this delicious product of the Sexton pure food kitchens?

# JOHN SEXTON & CO.



PRIDE OF THE WEST  
AND EDELWEISS  
QUALITY FOOD  
PRODUCTS

AMERICA'S LARGEST  
DISTRIBUTORS OF  
No. 10 CANNED  
FOODS

Established 1883

Specializing only in the supply of Hotels, Restaurants, Institutions,  
Clubs and Railroad Dining Systems

# For X-Ray Rooms

## TOCH'S

### No. 5700 Barium Sulphate and Lead Barium Paint

**H**ERETOFORE, the use of X-ray machines has been confined largely to lead lined rooms. The objection to this form of construction is its excessive weight and increased cost.

The invention and manufacture of Toch's No. 5700 Barium Sulphate and "R.I.W." Lead Barium Paint, which may be used in place of sheet lead with equal effectiveness, is a triumph of the Toch Laboratories, and were the first products offered for this purpose.

In the Toch Method the No. 5700 Barium Sulphate is mixed with the plaster or concrete during construction and the walls, ceilings and floors are then painted with the "R. I. W." Lead Barium Paint. This method is not only just as effective as the old one but decreases the cost.

*Write Dept. H. for further information*

**TOCH BROTHERS**

ESTABLISHED 1848

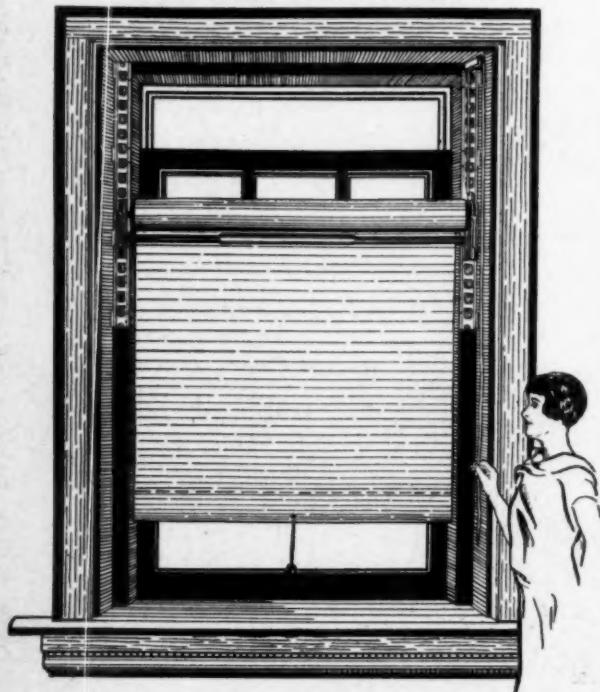
INCORPORATED 1922

Technical and Scientific Paint and Varnish Makers  
110 EAST 42nd STREET, NEW YORK

Works: LONG ISLAND CITY, N. Y.

## 2,000,000 HOSPITAL WINDOWS

### Need Window Shade Adjusters



Tomlinson's Approved Window Shade Adjuster fits any window—easy to operate—insures more light and better ventilation.

Manufactured and Distributed by

**THE JOHN K. TOMLINSON COMPANY**  
190 N. Clark Street Chicago, Illinois

from industrial plants that they might profitably adopt.

It might be said by some that there is not work enough in the smaller institutions to warrant the purchase of such a machine. Upon analysis, however, it will be realized that a comparatively small amount of surface will justify an installation. On flat surfaces a painter with a brush will work hard to cover 2,000 square feet in a day. Equipped with a spray gun, the same painter can easily cover 10,000 square feet per day. Not only does this result in a real economy in labor costs but it speeds the work of redecorating; the uniformity of paint application affords quicker drying, and thereby returns a room or a ward to service from one to three days earlier than is possible when the work is done by hand.

Any hospital that can keep a small spraying outfit busy one day a week, or two months of the year, has enough work to justify its purchase. This could not be said of any other institution than a hospital. But because our institutions already have the basic necessity—compressed air—an outfit for spraying paint in a hospital would cost only a fraction of the amount the average industrial plant must pay. The portable electric motor or gasoline engine compressor would be duplicate, and needless, equipment for the hospital. A spraying outfit, therefore, would cost the hospital no more than one hundred dollars—a justifiable investment when exceptionally large savings in labor costs and additional service from rooms can be obtained. This is true even when that one hundred dollar investment must stand idle in the storage or boiler room three-fourths of the time.

### Paint Dries Faster with Machine

Aside from the monetary economy of the mechanical means there is the added advantage of even, uniform application which affords quick drying. Taking the liberty of stepping afield again it may be said that one hotel, where formerly six painters were kept busy two days in the redecoration of the lobby, one paint spray machine was substituted. This substitution resulted in one man's performing the task of redecorating the lobby in six hours, which means in itself, a saving in labor costs equivalent to eleven men for one day. It further meant that the lobby could be completely redecorated in a night instead of filled with scaffolding for forty-eight hours. A battery of rotating electric fans kept the air in constant circulation and effected a complete drying in eight hours. Thus the lobby was completely redone in the hours between six p.m. Saturday and 12 noon Sunday. This is the sort of service that would be most appreciated by hospitals, as there always seems to be emergency cases when certain facilities are rendered inoperable by repair.

Another appreciated feature of such mechanical equipment is the ability to paint two coats with one application. When applied by air pressure there is no need to cover the surface twice as is the case when the paint is applied with the hair brush. Radiators, fire escapes, grill work, screens and other equipment of like nature can be easily and speedily covered with paint when air pressure is applied. It is on such jobs that spray equipment best shows its value in the reduction of labor costs.

There are countless ways in which hospitals can reduce maintenance costs and working expenses. The majority of these will be found in the comparison of methods and procedures between two or more institutions of the same type. Some, however, can be gained from the experience of those in other fields.

December, 1925

THE MODERN HOSPITAL

Adv. 83

*Actual Size*



*Opened by pressing finger on spring. Shuts tight when finger is removed.*

**Self-Closing Can**

**ZINC  
STEARATE  
MERCK**

While specially designed for use in the nursery, this new size package is very suitable for Hospitals too.

*It contains more than double the quantity of Zinc Stearate packed in Merck's well known sprinkler-top tin.*

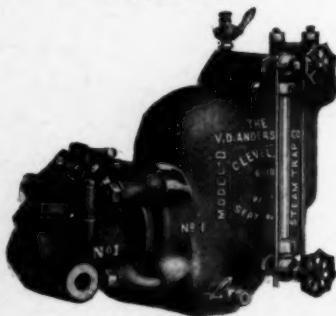
Dusted on lightly, Zinc Stearate Merck covers the skin with a thin, soothing water-shedding film which prevents chafing and helps to heal irritated or inflamed surfaces. Remarkably resistant to perspiration, dampness, and moisture.

*Samples free to Physicians, Nurses or other members of Hospital Staffs*

**MERCK & CO.**

45 Park Place, New York, N.Y.

Increase the Efficiency of  
your STERILIZERS  
with an



## ANDERSON STEAM TRAP

It is necessary to have hot, dry, live steam to get the best results from your sterilizers. An Anderson Steam Trap will help you obtain the needed dryness of your steam by removing all moisture.

There is an Anderson trap that will just fit your equipment. Let us tell you about the Anderson and give you complete information as to how it will help you.

**THE V. D. ANDERSON CO.**  
CLEVELAND, OHIO

## HOW WATER HEATER SAVES \$1500 A YEAR

The laundry of a 500-bed hospital in the Middle West formerly received its supply of hot water from a 2,000 gallon tank, located in the boiler room. The heater was of the old type, a tank filled with brass tubes or piping through which passed live steam. This construction brought on trouble because of the accumulation of scale in the tubes, and in the development of leaks that permitted the escape of steam into the water.

Realizing that live steam was expensive, and that scale was an insulator which materially hampered the passage of heat through the pipes the superintendent abandoned the old heater in favor of a new and larger one. The new heater, mounted on the roof of the laundry, has a capacity of 6,500 gallons. The water in the tank is heated, not by expensive live steam, but by exhaust steam and, since there is no coil or brass tubing in the heater, all trouble with scale or leaks has been entirely eliminated.

Details of the new hot water system can be seen from the accompanying diagram. The exhaust steam inlet is eight inches in diameter and is tapped directly to the main exhaust line. The tank is ten feet in diameter and fourteen feet deep. All water heating is done in the chamber just above the tank. A three horse power motor and centrifugal pump supplies the heater with water or, in the event that no water is needed, it provides circulation.

Upon the installation of the heater, a marked difference in the coal consumption was noted by the fireman. Analyzing this difference it was found that the new heater, although supplying the laundry with 50 per cent more hot water, was effecting a reduction in coal consumption of four tons a day.

Saving four tons of coal per day, in addition to making the fireman's work much easier, effects a monetary saving of \$5.35. This dollars and cents economy means a saving of \$1,952.75 in a year.

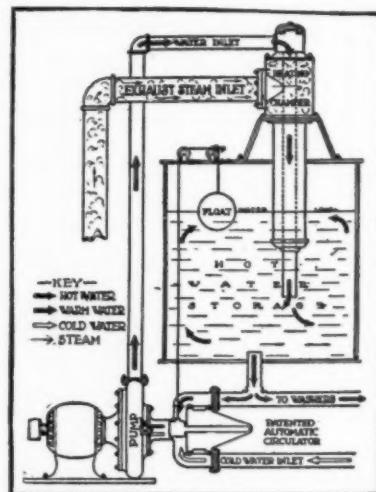
The operating expenses of the heater can be tabulated as follows:

6 per cent interest on investment of \$3,000.....	\$180
5 per cent chargeable to depreciation (20 yr. basis) .	150
2.5 per cent allowance for repairs (conservative) ..	75

Total annual operating cost ..... \$405

Subtracting the operating cost from the gross saving, gives a net annual saving in excess of \$1,500. This means that the installation, costing \$3,000 pays for itself every two years, or returns a fifty per cent interest on the investment. The saving is effected through decreased coal consumption alone.

The old 2,000 gallon heater has been retained and used as an emergency heater for house hot water, when one of the two regular house heaters is down for repairs.



# The Whistles Blew! and the Bells Rang!

**There was great rejoicing in old Marietta, Ohio**

### *For Ten Years They Talked New Hospital*

Last spring our representative met their Trustees and was employed for a fall campaign—

*When fall came, Every one said This is not the time for a campaign.*

1. Business is poor.
2. Many of our people lost heavily in unfortunate investments.
3. We all just subscribed to the limit, \$1,100,000 in notes, bonds, certificates to keep two important industries in Marietta.

### *But Marietta Needed a New Hospital*

The objective was increased from \$200,000 to \$250,000.

In the face of opposition—Promotion was pushed, organization effected and the battle started—

## \$253,000 was raised

with universal rejoicing

Just preceding this campaign \$1,800,000 was raised for the Reading, Pa. Hospital by the same director.

No Matter What Your Problem Is

### Let us meet your trustees

It costs you nothing. It may mean the solution of your financial problem.

**WARD, WELLS, DRESHMAN AND GATES**  
Metropolitan Tower, New York                    612 Wrigley Bldg., Chicago



## *Do you know these delightful uses for HAWAII'S "KING of FRUITS"?*

Of course you have served Canned Hawaiian Pineapple. Dietitians everywhere tell us that they couldn't possibly "keep house" without it.

But do you take advantage of all its wonderful menu combinations? Do you serve it in pies, ices, salads, fruit-cups, puddings—as well as right from the can?

As an indication of the host of reputation-making dishes which may be made with Canned Hawaiian Pineapple, we asked a leading food expert to make up a leaflet containing twelve recipes particularly suitable for hospital service.

Write for your free copy of this leaflet today—and, in the meantime, try these suggestions:

**South Sea Island Fruit Cup**  
Sliced bananas mixed with cold Crushed Hawaiian Pineapple. Canned cherry on top.

**Pineapple Shortcake**  
Crushed Hawaiian Pineapple sweetened and cooked until thick; spread between layers of hot sponge cake. Whipped cream on top.

**Baked Apple with Pineapple**  
Sweetened Crushed Hawaiian Pineapple, mixed with chopped raisins, in center of cored apples.

**Parfait Supreme**  
Beat sweetened whipped cream into well-drained Crushed Hawaiian Pineapple. Serve in parfait glasses over ice cream.

Address Department E-3  
**ASSOCIATION OF HAWAIIAN PINEAPPLE CANNERS**  
451 Montgomery St., San Francisco, California

# HAWAIIAN PINEAPPLE

**Sliced**

—For serving right from the can and for quick desserts and salads.

**Crushed**

—For sundaes, ices, pies, cake filling, salads and hundreds of made-up dishes.



## HOW TO MAKE A CRYSTAL CHRISTMAS TREE

Some of the northern municipalities employ a scheme for the decoration of parks or street corners during the winter season that hospitals might well adopt during the Christmas season. Properly executed, the idea will result in a beautiful sight and one that many patients will long remember. Any hospital possessing a fair-sized lawn or terrace can make the crystal tree without inconvenience.

Prop in an upright position a fir tree ranging in height from twelve to twenty feet. Decorate it with a liberal supply of colored electric lights, using small 8-watt bulbs. If colored bulbs of this size are not obtainable, the plain glass bulbs can be dipped in red, yellow, blue and green paints. Erect a water pipe to the height of the tree (fastening the pipe to the trunk of the tree) and affix to the top of the pipe an ordinary lawn spraying device.

When freezing weather has set in, turn on the water and thoroughly spray the entire tree. This spraying should continue throughout one night, in order to coat the tree completely with ice and form hundreds of both large and small icicles. In this way the tree will be literally overhung with ice and electric bulbs will be buried in the frozen water.

On bright days the tree will be most attractive, as every ice crystal will catch and reflect, in colors, the rays of the sun. It is at night, however, when the ice-coated electric light bulbs have been turned on that the tree will be most beautiful. The vari-colored light rays shining through the ice crystals and icicles will break up into a myriad of colorful short length light-waves and make the tree a picturesque spectacle. Such a tree can continue to stand on the hospital grounds for many weeks.

## BLOW OUT THE MANGLE MOTOR TWICE DAILY

Perhaps no electric motor in any hospital operates under more trying conditions than the one that drives the mangle in the laundry. In this work, the motor is certain to collect a great amount of lint and dust from the constant passing of the textiles. The presence of this foreign matter quite obviously lowers the motor's efficiency.

At one hospital it is a part of the regular duties of one man to blow out the motor with compressed air twice daily. Making the work a part of the established routine has resulted in minimized repairs, increased efficiency, and longer motor life. The blowing is done at 7 a. m. and 1 p. m., while all bearing-boxes and oil-holes are filled with a lubricant once each day.

The laundryman from whom this little method was learned pointed with considerable pride to the casing which housed the belt that transmitted the power of the motor to the mangle. He said: "We have had this mangle in daily operation for nearly seven years and have never had the casing off. The belt has operated so satisfactorily that I don't even know what it looks like."

Continuity of satisfactory operation is most desirable. However, we believe this laundryman is making a serious mistake in not inspecting every piece of equipment at least once a year. Knowing exactly what every piece of equipment is doing and how it is doing it, is a part of every mechanic's duties.

December, 1925

THE MODERN HOSPITAL

Adv. 87

F. W. WOOLWORTH CO. 5 AND 10¢ STORE



# Lorraine HAIR NETS 10¢

Lorraine Silk Nets  
with elastic edge. 5¢



Professional Women  
Value Highly This Aid  
to Trimness

PROFESSIONAL women know that no small part of their attire can effect so much charm and neatness as a Lorraine Hair Net.

Lorraine Hair Nets, cap shape or the popular fringe, are worn during the day to keep the coiffure of leisure hours charming and to protect the hair beneath a cap. Worn at night they make curls or waves last twice as long!

Buy a good supply of Lorraine Hair Nets at a time, so that you will always have a fresh one when you need it. No better nets are obtainable!

Sold exclusively at  
**F. W. WOOLWORTH CO. STORES**

For LONG HAIR—Full Size—Single and

Double Mesh—Cap and Fringe Shape

For THE BOB—Special Size—Double Mesh  
Cap Shape

# ALL-BRAN is safe and SURE for all

WHEN you wish to give bran to a patient, Kellogg's offers this advantage—it is ALL-BRAN. You know that the fibre content is large enough. You have an assurance that the results you anticipate will be achieved.

Perhaps this very dependability is the reason why Kellogg's ALL-BRAN is so often recommended by doctors and nurses, why it is used so constantly in hospitals. For you can't be certain of results from bran in which the fibre content is unknown. It takes ALL-BRAN to produce 100% results.

Kellogg's has a natural, pleasing, cleansing action. It does away for all time with habit-forming drugs and pills. And it has the advantage that patients delight in taking Kellogg's ALL-BRAN. The Kellogg process of cooking and krumbling gives it a delicious flavor—another distinction between Kellogg's and common bran.

Be sure to get Kellogg's ALL-BRAN. It is sold by all grocers.



What U. S. P. is to  
drugs, ALL-BRAN  
is to bran foods.

Send to the Kellogg Company,  
Battle Creek, Mich., for recipes  
and health pamphlets.

# Kellogg's

**the original ALL-BRAN**  
**—ready-to-eat**

## Book Reviews and Current Hospital Literature

### AN ELEMENTARY MANUAL OF PHYSIOLOGY

By RUSSELL BURTON-OPITZ, S.M., M.D., Ph.D., Professor of Medicine, New York Post-Graduate Medical School; Attending Cardiologist, Lenox Hill Hospital; Consulting Cardiologist, French Hospital, New York.<sup>1</sup>

The manual of physiology, by Dr. Burton-Opitz, while primarily written for use in colleges, schools of nursing and of physical education, is so simply and clearly presented that it bears study by the average reader. The contents are logically divided into the six divisions: the physiology of muscle and nerve; circulation of the blood and lymph; respiration; nutrition; the nervous system; and the sense organs.

The book is abundantly illustrated with colored and line drawings and with charts, unusually thorough in their graphic presentation of the essentials of physiology. The author has succeeded in disseminating physiological knowledge in a simple and interesting presentation.

### A SHORT LIFE OF FLORENCE NIGHTINGALE

By SIR EDWARD COOK; with additional matter and revision by ROSALIND NASH.<sup>2</sup>

Of interest to nurses and admirers of the precursor of modern nursing is Miss Nash's revision of the life of Florence Nightingale by Sir Edward Cook. Those who have read the book prior to the revision will find that the first chapter has been rewritten, omitting much of the matter concerning collateral relations and giving a fuller account of family origins.

A passage on nursing has been added and various paragraphs dealing with Miss Nightingale's character and personal history. The last chapter contains an entirely new discussion of Miss Nightingale's personality.

Aside from its biographical and nursing angles the book necessarily includes much on hospitals and hospitalization of the period. This is an interesting contribution to the history of the development of hospitals.—A. M. B.

### PHYSIOLOGICAL CHEMISTRY

By C. J. V. PETTIBONE, Ph.D., Associate Professor of Physiological Chemistry, Medical College, University of Minnesota, Minneapolis, Minn.<sup>3</sup>

This intermediate textbook on physiological chemistry aims to cover the general field in such a way as to give students of this subject a working knowledge of compounds important from a biochemical viewpoint and to familiarize them with the fundamental processes that are taking place in the animal body.

A considerable amount of material bringing the text up-to-date with respect to recent developments in physiological chemistry has been added to the revised edition.

<sup>1</sup>. Second edition, revised, W. B. Saunders Company, Philadelphia and London, 1925.

<sup>2</sup>. The Macmillan Company, New York, 1925.

<sup>3</sup>. Third edition, the C. V. Mosby Company, St. Louis, 1925.

## INDEX TO THE MODERN HOSPITAL

VOL. XXV

JULY TO DECEMBER, INCLUSIVE, 1925

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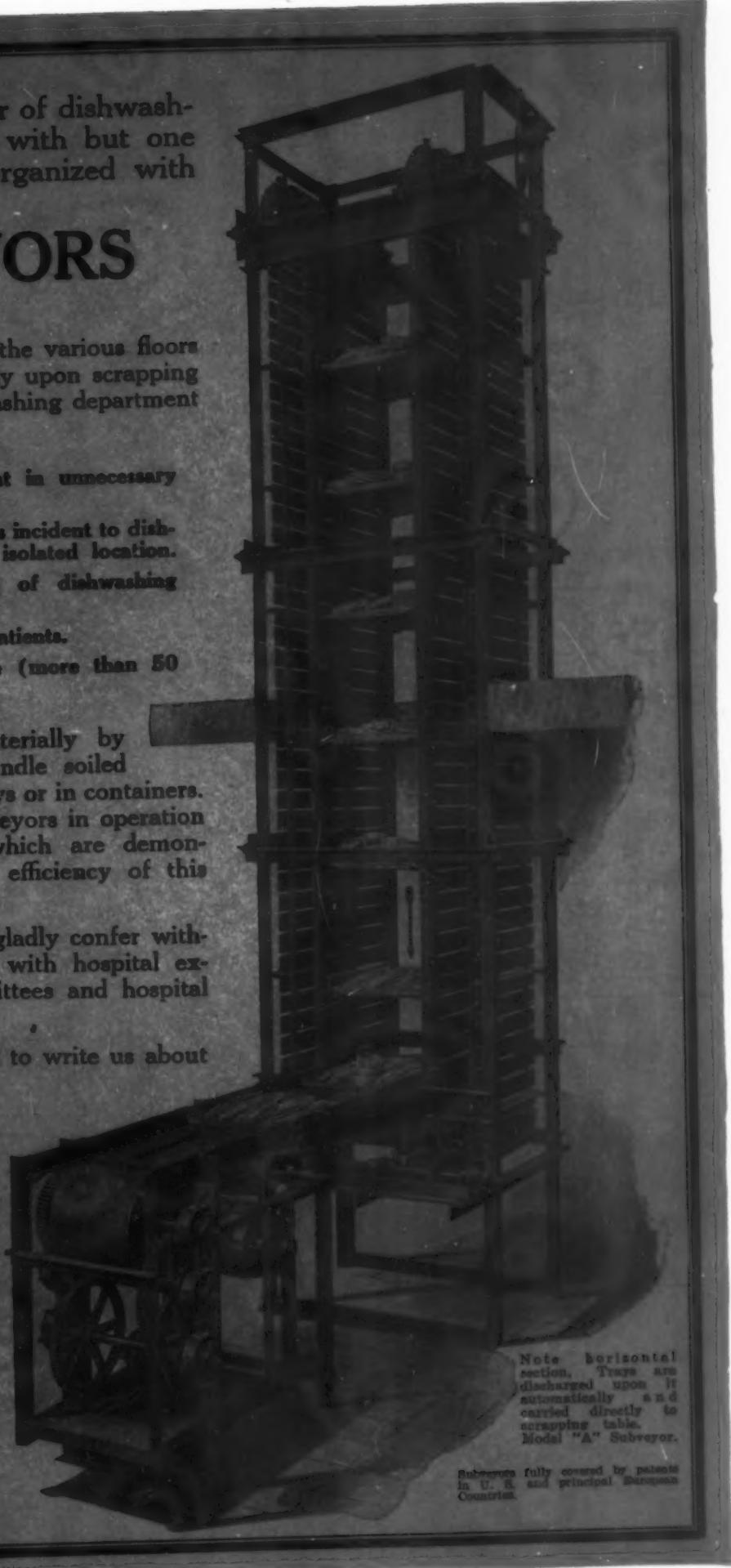
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